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Reader's Guide

During the past twelve months, your editor has been privileged to visit every province in Canada and to speak to thousands of nurses. This form of contact is exceedingly valuable in building up a larger and more aware group of subscribers and readers. It is even more worthwhile because of the opportunities thus afforded to meet future authors of *Journal* articles, to interest the nurses who are giving the care in our hospitals, who are making the visits in the homes, to describe their work for us. One very gratifying result of these tours, therefore, will be the steady flow of articles on new and different topics which will be published in the months to come.

Another practical and advantageous result of these visits has been the acceptance by scores of superintendents of nursing of the proposal that the *Journal* be regarded as a required text for student nurses. We are all aware of the relative ignorance of many of our young graduates regarding the activities and accomplishments of their professional organizations. The most propitious time to foster this interest is during the undergraduate period as an integral part of the whole learning process. This has always been the philosophy of the Executive Committee in its provision of a special subscription rate for the *Journal*. To further this purpose, series of questions based on the articles in the *Journal* are prepared every three months and will be distributed on request. The study of these questions would form a useful topic for chapter meetings also. Write us if you would like to receive copies.

Dr. Walter J. Fisher has given us a very detailed description of the reactions which may be expected from the various forms of shock therapy which are being practised today in the treatment of mental illness. Dr. Fisher is a neuro-psychiatrist in Saint John, N.B.

Penicillin is being used in such enormous quantities in our hospitals today, that the mere physical task of administering the required dosage at properly spaced intervals looms as an important factor in assigning ward duties. The program which has been described for us by **Sister M. Décary** should assist considerably in lightening this task. Sister Décary, who was formerly director of nursing at Notre Dame Hospital, Montreal, now occupies a similar position in St. Peter's Hospital, New Brunswick, N.J.

Priscilla Campbell, administrator of the Public General Hospital, Chatham, Ont., has made an enviable name for herself in rousing and maintaining public interest in nursing. Her personal scrap-books are filled with hundreds of newspaper clippings—mute evidence of her ability. She has excellent ideas.

So that you may be familiar with some of the present-day trends in nursing when you launch your publicity programs, we are pleased to bring you the thoughtful analysis prepared by **Eleanor MacIntosh.** This material was presented to the staff nurses meeting at Toronto Western Hospital where Miss MacIntosh was engaged as science instructor. She is now on the staff of the School of Nursing, University of Alberta.

Dr. Charles H. Gundry is the director of School Health Services, Division of Mental Hygiene, with the Metropolitan Health Committee, Vancouver. **Mary Rowles** has had a wide experience in many branches of nursing service. You will remember her as winner of the first prize in our 1946 article contest. At the present time she is industrial nurse with the Dominion Glass Co. Ltd., Redcliff, Alta.

Dorothy G. Riddell, inspector of Training Schools with the Ontario Department of Health, Nurse Registration Branch, provides us with a comprehensive picture of the organization and program of training for the nursing assistants in Ontario.

Canadian Nurses' War Memorial

When any one of you is asked to give a lecture or group of lectures on any nursing subject, what is one of the first things you do? Is it not to gather around you the latest nursing textbooks and journals and from these and your own personal knowledge and experience draft your lecture or lectures?

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(*Please turn to page 870*)

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1. J.A.M.A., 128:490, 1945.
2. Am. J. Obst. & Gyn., 48:510, 1944.
3. Am. J. Obst. & Gyn., 46:259, 1943.
4. West. J. Surg. Obst. & Gyn., 51:150, 1943.

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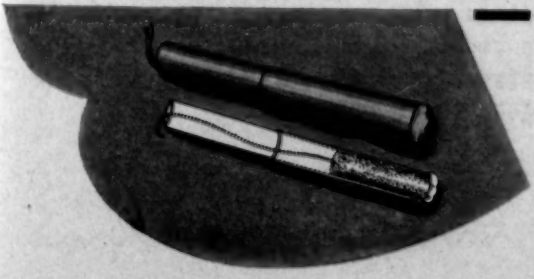

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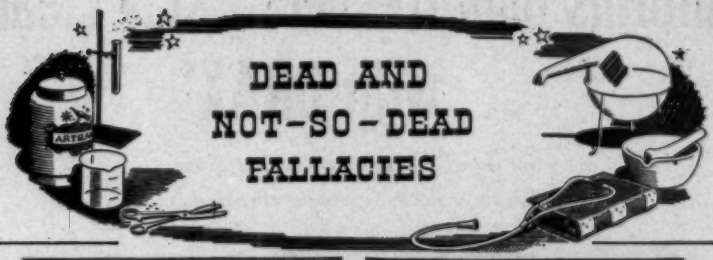

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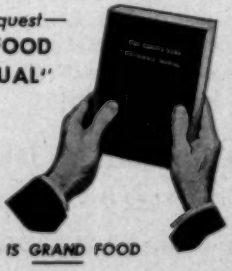

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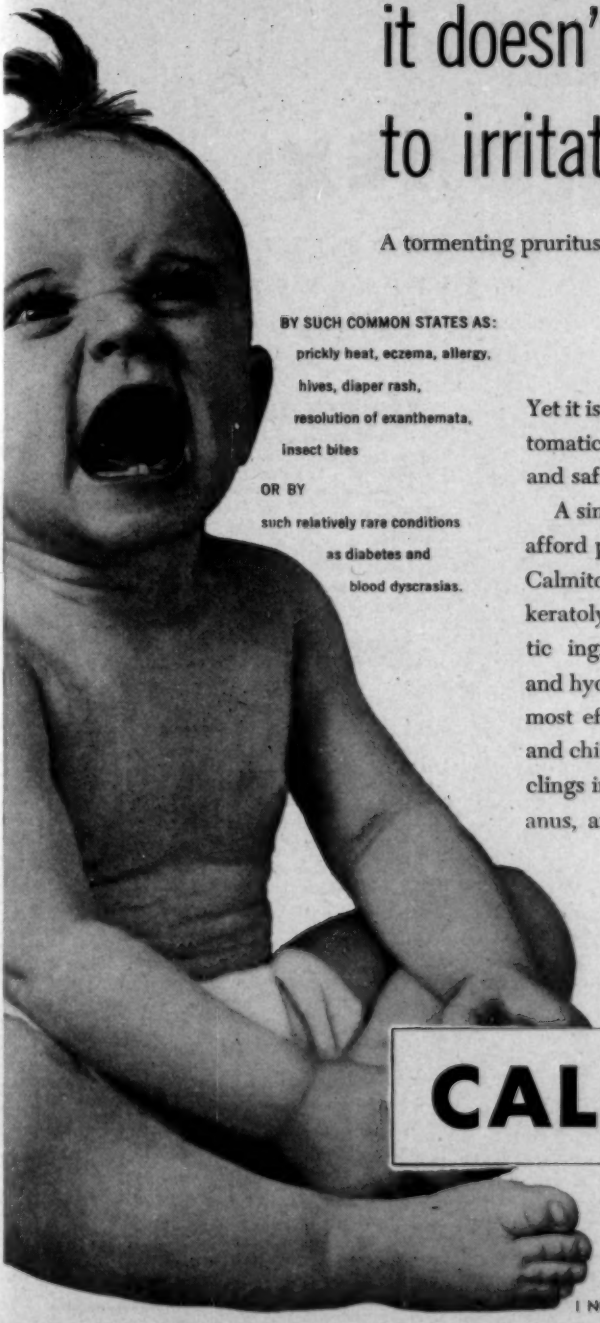

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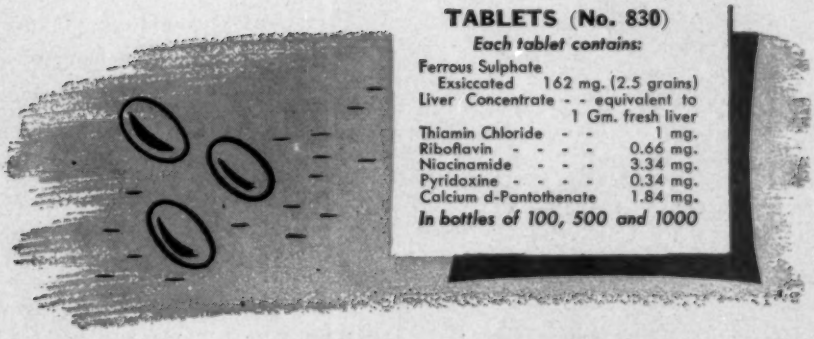

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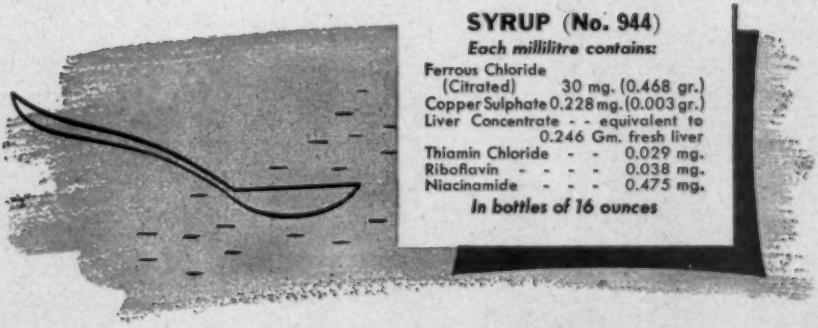

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PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-THREE NUMBER ELEVEN

MONTREAL, NOVEMBER, 1947

Creating Rapport

EVERY NURSE working in any hospital today is closely, personally, familiar with the feeling of rush and urgency that busy wards and too few pairs of trained hands has precipitated. Every nurse giving bedside nursing care in the homes is aware of the amount of work ahead of her which must be accomplished in as short a time as possible so that other jobs may also be fitted into a day's work. Every nurse engaged in other aspects of community health work is similarly conscious of the driving force which is the inevitable accompaniment of the present-day so-called nurse shortage. There is no magic formula which can reduce all this hurly-burly to a simple problem which any one of us can solve individually.

At this time it may help matters somewhat if we pause long enough to adjust our thinking to the patient's point of view. What does it feel like to be one of the focal points of this mad whirl? How can the nurse successfully reach the patient and convince him that he, as an individual, is important.

The primary factor which every nurse, be she student or graduate, must strive to develop, the axis about which her various duties revolve, is the relationship which she is able to establish with the patients. In order to facilitate an agreeable and satisfactory rapport, it is necessary for each nurse to understand the basic concept, which is her attitude to the people whom she is serving.

The advantages of creating good rapport have long been recognized, especially in modern hospitals for the care of the mentally ill. Perhaps there more than elsewhere rapport is stressed as a cogent factor in recovery. It can be applied with equal value and significance in every nurse's work.

Let us, therefore, examine the qualities, the attitudes, which are essential to the creation of a smoothly-functioning rapport. Rapport is the communication, the relationship which exists between two individuals. No hard and fast rules may be laid down as to how it may be built up. Each nurse must follow her own personal pattern. The following qualities are

inherent in its development. Conscious attention to the development of these attitudes will work wonders.

Courtesy and tactfulness, which are closely allied and are necessary for agreeable relationships with all people, but particularly with those who are ill.

Friendliness, which embraces confidence and hospitality.

Patience, which when it is real is translated into interest.

Truthfulness, best demonstrated by earnestness of manner and sincerity of purpose.

Even temper, which is absolutely essential when dealing with those who are emotionally upset.

Non-critical attitude, which is best shown by the ability to refrain from making unkind remarks about the patient's idiosyncracies.

Poise, displayed by the absence of a sense of superiority, by calm gentleness instead of excited rushing about, by the avoidance of words of anger even in the face of trying experiences.

While every nurse must ultimately work out her own technique for creating rapport, each time it is successfully achieved the method will become more sure and involuntary. Having established rapport, the wise nurse will ensure that no act or word of hers will destroy it and thus undermine the patient's confidence in her. She should deliberately determine that her business in life is to exercise a constructive influence on her patients. Their restoration to health and their subsequent regard for nurses and nursing depends to a very considerable extent upon the rapport that each individual nurse is able to create. Thus, she is not only building a sound reputation for herself, she is strengthening the status of the whole profession of nursing — a worthwhile contribution.

What proof have we of the results of successfully-created rapport? Every hospital receives letters expressing gratitude, not only for the care that has been given but also, indirectly, for the rapport that was established. The following excerpts from a letter we have just received illustrates the point most graphically:

> May I request you to insert my "Vote of Thanks" in your nurses' magazine.
>
> I was on a recent visit to relatives when unforeseen circumstances made it necessary for me to undergo an immediate operation. The nearest hospital was in T where I consulted Dr. R, surgeon. His approach was one of kindly interest so I decided (in spite of my fears) to place myself in his hands.
>
> I was so well cared for and also shown such real consideration by the hospital staff that I feel they deserve an appreciative acknowledgment.
>
> Having taught school for forty-four years and enjoyed the lion's share of kindness and understanding, I feel I owe this public acknowledgment to the members of the hospital staff.
>
> I am, Yours gratefully,
>
> Mrs. F. S.

Good public relations are vitally important. Creating an easy rapport is the first step in building public appreciation, understanding, and eventual support. It *is* worthwhile.

— M.E.K.

A Princess Weds

NOVEMBER 20, 1947, will be a gala day in Britain in spite of the austerity demands which circumstances have forced upon a gallant people. Not only in Britain but throughout the Commonwealth and the world, millions of people in all walks of life will pause briefly and silently breathe a prayer for her happiness as Her Royal Highness, Princess Elizabeth, is married. The ever-growing throng of nurses in Canada

unite in adding their good wishes to the mighty chorus.

The world has watched the steps in the training of a future queen with interest and admiration. The determination of her parents that she should enjoy a full, rich, care-free childhood; that, so far as was humanly possible in the midst of State duties and a full program of public engagements, the princesses should have a natural family life, has strengthened this pattern of living beyond any words. Princess Elizabeth's education has given her a breadth of knowledge and understanding befitting the responsibilities of heiress presumptive to the British throne. She has also shown a great capacity for enjoying outdoor sports and activities.

As nurses, we are all aware of the sincere interest Princess Elizabeth has taken in the care of the sick, the wounded, the helpless. As president of the Student Nurses' Association of the Royal College of Nursing, in Britain, she has closely identified herself with nursing activities. The sense of responsibility which has been implanted in her is reflected in the words which she spoke to the Empire on the occasion of her twenty-first birthday broadcast:

> There is a motto which has been borne by many of my ancestors — a noble motto, "I serve." . . . I declare before you all that my whole life, whether it be long or short, shall be devoted to your service and to the service of the great imperial family to which we belong . . . God help me make good my vow, and God bless all of you who are willing to share it.

The nurses of Canada have a special reason, therefore, for taking the happy couple to their hearts and wishing them well in this their wedding month.

Shock Therapy

WALTER J. FISHER, M.D.

IN RECENT YEARS the interest in psychiatry has steadily increased and, hand-in-hand with it, a widespread knowledge of the modern method of treatment. The laity is today aware of the term "shock therapy" and often when we are consulted, immediately the desire for the appliance of this "shock treatment" is expressed. Let us, therefore, examine what shock therapy is, when and how it is used, and what are its limitations. Mental diseases are not a modern invention, but may be as old as mankind. We find them mentioned through all the historical ages, and we find also mention in the olden times of some therapeutic manœuvres, gruesome and cruel, frightening and shocking. This means of helping the sick ones can certainly not be regarded as the predecessor of our modern shock therapy. The fundamental difference lies herein; our modern shock therapy acts when the patient is in an unconscious condition; the medieval treatments were applied only to a conscious patient. He was, therefore, treated on a psycho-therapeutic pattern.

When we speak today of shock therapy, we think first of insulin shock and, second, as somewhat opposed to it, of the convulsive therapy, divided into a pharmacologic convulsive treatment: the metrazol shock and the electric shock. As often seen in medicine, the space of a few years has brought forth a new way in therapeutics, approaching the goal from different angles. It is amazing also to see the way in which the men who made these discoveries found the conception of their ideas. Insulin was used for treatment in psychiatry long before. The idea was to raise the

weight of the excited patients and then to combat their excitement. The HC was carefully avoided and on this point Sakel recognized, with the gift of a genius, the importance of a phenomenon which became the central idea of his new treatment. Certainly many people could have seen, and saw, before Sakel, HC but they were not critical enough to visualize this process.

In 1933 Sakel gave his first report at the University of Vienna, and although today some changes in the method of his treatment are made, the general idea has remained unchanged and the observations of Sakel can be regarded as classics. As our country has given the world insulin, you should all be familiar with the term HC. This means the appliance of insulin in such an amount that shock results. This dangerous shock, avoided before Sakel, is now the goal of the insulin shock therapy. You can easily understand that a patient cannot be brought carelessly to a shock condition. There is a definite technique which has to be followed.

As a rule, the insulin shock is given in a special ward. The carefully selected patients, whose temperatures are taken each day before treatment, start their treatment at 7:00 a.m., without having received breakfast. Under normal conditions, it is essential that a supervising physician and a supervising nurse with their full staff be present for the duration of the treatment which lasts four hours. This period is divided into special phases but, as reaction and complication may occur at any time, it is certainly wise not to leave the patients without supervision. We have our charts with the regular weight of the patients and with their temperatures. We do not treat febrile cases. Special care has to be given to the temperature and humidity in the treatment room, and also the beds should be chosen so that injury during the excitement of the patients can be kept at a minimum. It is the belief that undernourished patients and excited patients should not be excluded from the treatment.

Opinion is not unanimous about the amount of insulin which should be used in order to produce a coma. Some doctors use as much as 1,000 units, whereas I never had to use more than 150, an amount which is approved by the greater number of physicians. We start with 20 units per day and increase slowly, about 8 units per day, until we reach a coma dose. The treatment is given six days a week, Sunday being the day of rest. The injections are given deeply intramuscularly, and the patients must be watched for the development of some sensitiveness against insulin or some allergic reactions. This is one of the reasons why we start with so small a dose. If a reaction occurs, it is often sufficient to change from one make of insulin to another.

About *one* hour after injection, the appearance of symptoms of HC starts. The patient feels sleepy, begins to perspire, and there is increased salivation. There may be complaints of hunger and thirst. In the *next* hour these symptoms increase, the consciousness becomes clouded, the patient appears drowsy — he sleeps. There is a group where the picture presented by the patients is different. We find these in a state of excitement, they try to get up, they toss around, they shout and yell. With the *third* hour, the real HC comes on. It is the goal of every therapist to give the insulin in such an amount that the shock starts in the third hour. Therefore, when the shock starts too early, the amount of insulin has to be reduced. When it starts too late, the amount has to be increased. It is hard to determine what a coma really is. It is interesting to note that many scientists use different criteria for a coma. It might be sufficient to state that in shock or coma the patient does not respond to any stimulus and cannot be awakened. During the coma the patient shows twitchings, absence of reflexes, and presence of pyramidal signs. At the same time, the face becomes flushed, the pulse is accelerated, and the pupils are dilated. At the beginning of the *fourth* hour the pupils do not

react to light, the eyeballs are turned to one side, the pulse accelerates still more, and the patient appears cyanotic. Spastic waves come on, and the pupils later contract. The pulse rate formerly high begins to slow down, and the respiration is forceful. This is reached at the *fifth* hour. Such a comatose condition should not exceed fifteen minutes during the first treatment, and it should never on repetition last over one hour. The deepest part of the coma should never extend more than twenty minutes

When you hear that in some cases 1,000 units of insulin are given to produce a coma, you will be interested to learn that I have seen a coma after the administration of only 8 units.

What steps are taken to produce coma when it does not commence on daily and correctly increased dosages of insulin? In such cases, we use one of the so-called zigzag methods. This means the rapid dropping and increasing of dosages. By this means a coma is often reached with a dosage which previously was not enough to produce therapeutic effect.

When the coma has lasted long enough, the treatment has to be terminated, and this is done by different means. Sugar solution may be fed by mouth if the patient can swallow, or through a nasal tube. However, the danger in the latter method is that the patient, who is still unconscious or semi-conscious, will not produce the warning signs that the nasal tube lies in the wrong place. The third and most important way of terminating a coma is the use of glucose solution intravenously. Here the complication lies in the fact that the repetition of this injection leads to closing of the veins. For emergency manipulation, one vein at least should be in proper condition so modifications of treatment have often to be adopted.

When you visualize the various hours of a treatment day and the reaction which the patients produce, you will understand that the treatment room has to be equipped with everything that is necessary to counteract any complications which may arise.

It is believed that fifty to sixty comas should be applied before insulin treatment has to be discontinued. This number should never exceed one hundred as there is a danger of brain damage. Such brain damage may occur after a so-called protracted or prolonged coma — one in every 1,800 cases — which may last for days. The patient is always in a dangerous condition, which occasionally leads to surprising improvement, but more often causes irreparable brain damage, or may lead to death.

Numerous references in literature deal with the observation on body fluids, with findings on heart actions, pulse rate, electrocardiogram, and so on, but these will not be discussed here. As to the psychiatric observation, I would remind you that even a normal person under insulin shock therapy would act rather oddly. We have to assume that there is a typical reaction which follows the overdosage of insulin. It is very hard to distinguish what is due to this intoxication, and what is due to hallucinatory processes which flare up during treatment of our patients. Our patients are able to report their own reactions during the first few hours, but there are only a few reports covering the real coma.

It is interesting to watch the awakening from HC. First the reflexes reappear, then the motor functions become normal, patients respond to stimuli, and lastly their speech will be normal. Most patients have their own way of awakening, and do not change it during treatment. Immediately after termination, patients appear relaxed, they ask for food, they start conversation, and they are definitely more in close contact with the real world. After a few hours, they may swing back to their psychotic signs and live again in a dream world. As insulin treatment brings improvement, the hours of well-being begin slowly to lengthen, and the intensity of the psychotic phenomena fades slowly away. The

hallucinations become fainter, the voices are farther away and more indistinct.

The best thing which we can hope for with our treatment is to improve the patient to such an extent that he is nearly or absolutely as he was before the acute disease developed. Our patients often show signs of having been introverted many years before an acute process started. You will understand that we do not expect to alter the pre-psychotic personality, but will see the patients just as introverted as they have been before they became acutely ill. Despite all observations made so far, we do not know what really takes place in the brain and what changes cause improvement, but we do know that insulin treatment is the ideal treatment for special forms of schizophrenia, especially the paranoid and catatonic forms. It is definitely the treatment of choice when these forms have not been present longer than one year. Whatever skepticism we may have, each patient who can be treated should have the opportunity. This conclusion is derived from the fact that today we are not in a position to make a clear-cut diagnosis as to which group the patients may belong in.

I have tried to give some outline of the treatment with insulin. I would like to point out now only one phenomenon. Occasionally during the insulin shock treatments we see the occurrence of real epileptic seizures. This brings us to the second form of therapy in which these seizures are just our goal. A few observations regarding the convulsive therapies will indicate their value.

There are two convulsive therapies, one performed by the injection of metrazol. It was von Meduna who, in 1935, reported on his new treatment for the first time. He came to his conclusions under peculiar considerations. It was known that schizophrenics very seldom suffer from epilepsy, and so he thought that one disease might rule out the other. The use of metrazol, a camphor preparation, has a predecessor. In the year 1785, an Englishman named Oliver reported on the treatment of mania in the *London Medical Journal*. It was the belief that the convulsive therapy would turn out to be a treatment for schizophrenia, as is insulin, but it developed that the use of the convulsive therapies lies mostly in another field.

This drug, sometimes up to 40 cc., is given intravenously. Between three and thirty seconds later, a very brisk convulsion occurs, but the interval between the injection and the convulsion, short as it may be, produces a fear of death on the patient, so much so that he often refuses a repetition of this treatment. This feeling of impending death and sudden annihilation, together with a special type of epileptic seizures which often bring on severe fractures, is responsible for the fact that electric shock therapy is gaining steadily in popularity, whereas the metrazol treatment seems to be on the decline.

In 1937, Cerletti and Bini introduced the electric shock therapy. Small electric sets are used for the application of this treatment. The patient is placed on a flat table which has a hard mattress as the best covering. The spine is bridged over a sand bag. Artificial dentures, hairpins, etc., are removed. It is a good idea not to give the patient any or very little food before the treatment. A paste is then applied to the area over the temples and on these spots a special forceps is applied in order to conduct the current to the patient. Why is just this area chosen for the appliances? The various parts of the brain do not equally admit electric currents. This area has the lowest threshold. After the resistance of the patient is measured, the current is again set in motion, and in a very short time a seizure occurs which is absolutely equal to the real epileptic seizure. As it develops slowly, and, of course, can be adjusted in intensity, the danger of fractures is less than with the metrazol treatment.

It may be interesting to point

out that the threshold is different in each sex, and that the threshold increases in older people and also on repetition of the treatment. Curiously enough, hours and sometimes weeks later electric currents can be found in the brains of patients, currents which definitely were not there before the treatment was set in motion. These currents do not cause any harm and there seems to be no connection between them and the results of the therapy.

The temperature and humidity of the air is of importance in this treatment. On cold and dry days, the threshold is higher.

The patient, having developed *grand mal*, comes out of it very quickly. He is confused and may complain of headache and dizziness. The patient, who has responded with *petit mal*, may become temporarily confused, but in both cases we find amnesia. The patient who has known his doctor for weeks and months will not recognize him at all. Many of our patients complain of impairment of memory which gradually improves.

Fractures may occur with electric shock. One of the most common complications is the dislocation of the jaw. Many doctors stress the danger of fractures so it is wise to protect when we suspect very weak bones, by x-ray of probable areas before treatment is started.

Between five and twelve electric treatments are given, from two to three a week, but should a relapse occur there is no reason why this treatment cannot be repeated. The chances on repetition are just as good as before.

Some physicians use a preparation developed from curare. The use of this old Indian poison blocks the communication between the nerves and muscles. In other words, its use in our therapy is as a breakwater which does not permit the impulses from the brain to reach the muscles, or they may reach the muscles only in a very mild form. The use of this preparation has some disadvantages also, and the majority of therapists do not use curare generally.

One word regarding the fatalities in shock treatment should be added. A survey in all American hospitals reveals the following death rate: 0.06 per cent for electric shock therapy; 0.1 per cent for metrazol; and 0.6 per cent for insulin.

Generally we use the insulin treatment for schizophrenia and the convulsive treatment to combat depression. When we have to deal with affective disorders the convulsive treatments are the treatments of choice, but it is with real depression and the depression occasioned by the menopause that electric shock therapy is most effective. There are reports which speak of from 80 to 100 per cent remissions. Whereas the insulin treatment is most hopeful when the patient has not been ill longer than one year, time does not play a part in the convulsive treatment.

Recent years have given us the armament to combat actively certain psychiatric phenomena. For a long time there was a belief that psychiatry was missing out by not using active therapy. This outline shows a branch of active therapy which is now used, and very successfully, all over the world.

Advice to Physicians—Vintage 1100

A guide book for doctors written about the year 1100 in Salerno, Italy, under the title of *The Physician's Visit*, gave this advice to the doctor: "When called, commend yourself to God and the angel who guided Tobias. Learn as much as you can from the messenger so you may astonish your patient by your knowledge of the case. When you arrive, sit down, take a drink and speak of the beauty of the country and the house. Next feel the patient's pulse, but remember that it may be affected by your arrival, or by the patient's thinking of the terrible cost of your visit. Tell the patient you will cure him, with God's help, but tell his friends that the case is very serious."

Start Talking!

PRISCILLA CAMPBELL

NURSING MUST TELL ITS OWN STORY

LACK OF INTEREST, respect, and support can be fatal to the life and effectiveness of any public service. The chief reason for lack of interest, understanding, and support of nursing lies in lack of interest and aggressiveness on the part of organized nursing to tell its own story, present facts and figures, and emphasize the responsibility that enjoins upon every nurse from early student experience on through to the top-ranking members of the nursing profession.

The story has its origin in a proud and honorable record of service rendered on behalf of a great and noble public, a story which will bear telling again and again and with pardonable pride. This fact is sometimes referred to at nurses' meetings and perhaps on the occasion of such auspicious public functions as a School of Nursing Commencement. From there on the community gets its information about nursing wherever and however it may — from incomplete reports, half-truths, and sometimes unfounded rumors. Members of the profession seldom are prepared to answer questions about nursing or to speak freely and with confidence on behalf of this essential public service.

Self-expression and the expression of an organization such as nursing takes many forms. It is projected by the smallest details in actions, manners, speech, attitudes, and writings of its members. It is our privilege, our duty, and our responsibility to give a good account of nursing. We live in a society that offers rewards only to those who can interest, impress, and inspire the abilities and effort of others on behalf of the cause in which we ourselves are interested.

LEADERSHIP

The penalty for a job well done is another and even more important task to be undertaken. Leaders in nursing must take on another important assignment this time. We must organize and direct a carefully planned program of public education designed to inform church organizations, civic bodies, women's organizations, service clubs, students in secondary and special schools, and citizens generally about nursing—how the present system of schools for student nurses is organized and operated; what is contained in the basic educational program for the student nurse; what the nurse education program costs per student; who pays for it and who employs the qualified registered nurse upon completion of her basic training.

Off in the distance I hear a voice protesting — the public does know about nursing! They seem to know when they want nursing service. Certainly they do; but they do not know how this essential health service is provided and maintained. Why do they not know? Because you and I have not taken the time nor put forth the necessary effort to inform them. We have allowed persons uninformed to speak publicly on behalf of nursing. Every nurse must share in this task and we all have endless opportunities to speak of nursing if we will take the time and make the effort to do so. The times in which we are living provide for nurses their greatest opportunity to do just this. Nursing activity is in the news. People are interested and are asking questions and we must be prepared to answer. It's easy to get attention now. We must be prepared with the facts and state them openly, tactfully but frankly. If we do not convince all our listeners on the first attempt, we must accept disappointment gracefully. We must never stop trying.

THE NEW RECRUIT

Our program of public education must commence with the newest re-

cruit to the nursing ranks. It is, therefore, essential that we begin at the beginning with the most junior student immediately she enters the nursing school. Special effort must be made to interest, to stimulate, and to maintain her interest in nursing. This may be accomplished by spending more time informing students about why and how schools of nursing are organized and operated, according to the present system; what is contained in the nurse education program; the value of a clearly defined department of nursing within the hospital; and, right here, why and how nursing must tell its own story to the community; why it is essential that we must improve our relations with the public whom we serve; and how the youngest recruit may assist in this achievement. Give to the student of nursing the kind of experience and education in which she can take pride; compile facts and figures for her; give her some instruction in public speaking; encourage her to talk about nursing to her friends; and to feel that it is her privilege and her duty to speak freely about one of life's finest experiences. Let us once and for all get rid of the ancient idea that has prevailed for so long, and still is evident, that the nurse is a self-sacrificing soul who must be seen only at the bedside of the patient and seldom if ever heard to speak outside a meeting of nurses.

The Qualified Registered Nurse

By their works you shall know them — is a time-tested proverb. Achievements speak the loudest of all of the factors of public relations. The cornerstone of a sound, effective public relations program is the provision of quality service. The assignment to be undertaken is not a task for the few. It is a program in which every qualified registered nurse must share regardless of time or special talents. It begins with the superintendent of the school of nursing and director of nursing services whose job brings her into contact with many and varied people from all walks of life. Her opportunities to give a good account of nursing by action and by the spoken word are unlimited. The department supervisors and nurse instructors share with their superior in spreading goodwill, understanding, and appreciation. If interests are directed into the proper channels, the general duty nurse forms an important link in the chain and can assist to a marked degree in the influence and benefits of the program that has been planned and put into motion. She must be in complete accord with the policy and principles of the task in hand and must concern herself with quality nursing service.

The private duty nurse enjoys one of the most excellent opportunities to give a good account of nursing in terms of services rendered, and in conversation with her patient, his friends, and neighbors. She too must make quality service her ideal. No nurse makes a greater or more lasting impression.

The public health nurse through her special department of nursing enjoys a wide range of community contacts as a health teacher and guardian of our most priceless possession. The school nurse, through contact with the children and their parents, can be the ideal nurse in the community. She can, if she will make the effort, inspire in the minds of youth a confidence and respect for nursing that few other nurses have an opportunity to accomplish. The industrial nurse now takes her place alongside the sons and daughters of industry, tending their wounds and offering advice on matters of health and welfare to the employee and his or her dependents. Industry has been quick to recognize the value of the services of this trained worker in keeping the wheels turning. With proper leadership, industry can wield a powerful influence on behalf of nursing.

Public Relations

Public relations programs are measured in terms of public interest and social value. Do they deserve to succeed because they contribute to public welfare? Do the persons

actively engaged in them have a highly developed sense of public welfare and public service?

Interest and assistance will be forthcoming only when we as nurses go out after it. The community expects to receive this information, inspiration, and leadership from nurses.

The Trustee

Now that we have undertaken a campaign of enlightenment for our members and have put at least a part of our plan to the test, we may venture to discuss the much-needed assistance of the trustee. We realize full well that nursing is a community service. We as nurses cannot carry the responsibility for the service without community interest and support. This interest and support can best come through the efforts of volunteers acting in the capacity of trustees serving as the link between the nursing organization and the community which it serves.

Hospital and nursing school trustees, as I know them, are public-spirited men and women with varied interests and experience, each possessing public service ideals and a desire to contribute in time and personal effort to the development of a worthy community project. For the particular task before us, the trustee must be chosen with the utmost care and consideration of his personality, ability, personal interest, knowledge of community needs and community welfare. After the selection and appointment of the trustees, be they ever so promising, we cannot heave a sigh of relief and relax. No indeed! Not by any means. Too much of that has already been done and with nearly disastrous results. We must be willing to spend extra time and make special effort to keep our trustees informed about nursing needs. We must not expect these good folk, regardless of their zeal for the cause of nursing, to understand nursing organization, operation, and service. This will come slowly and we must be patient. If we truly want our cause to progress, we will gladly spend the time and effort, and miss no opportunity to discover just what the trustee's attitude and special abilities are; what his business and social interests are. We will bend every effort to keep our trustees informed and in touch with all sources of information on nursing. It is a special piece of work worthy of special attention by all our members

Charlotte Whitton has once again pointed out, in a timely and well thought out article about women in public life, that it is time for women to learn the facts of political life — civic, provincial, and federal. I agree most heartily and would venture to suggest that it is time the nurses of Canada as a national organization were thinking in terms of political leadership and that we now select and prepare one of our members possessing special qualifications for such a post. Oh yes! I know we may be shocked at the idea. We were also shocked to find that the small amount of funds from the government treasury, voted in support of nursing education during recent war years, was one of the first government expenditures to be cut as soon as hostilities ceased. The presence of a nurse at Ottawa probably would not have altered this. However, she would at least have questioned such a move, and would have suggested reasons why this curtailment should not have been made. Enlightening information and advice on behalf of an essential health service could be frequently offered. Opportunities would have to be sought to present facts and figures on nursing needs and nursing costs to the money-spending bodies. One can readily visualize the presence of the especially well qualified nurse executing a marked influence on behalf of a public service that is little known to governmental bodies. Someone has already said, "How do you think you are going to finance such an undertaking?" Canadian nurses have raised money before — large sums of money for other worthy projects — and they can do it again. We have been reminded that time is running out and that an election is in the offing. We had better face up to the facts

as they exist, consider nursing problems as they are today. Otherwise we shall be standing by watching a public service essential to the life of Canada become a pale shadow of the dignified and honorable public service that organized nursing should perform.

Hospital Penicillin Treatment Centre

SISTER M. DÉCARY

THE ADVANTAGES of penicillin therapy in the treatment of certain diseases are so obvious that physicians are prescribing this antibiotic more and more frequently. In order to obtain good results with penicillin it is absolutely essential that the required dose be given at regular time intervals and for this reason the patient is generally hospitalized.

The patient submitting to the treatment has a right to receive the prescribed amount of penicillin at the time intervals specified by the doctor to ensure a rapid recovery. He also has a right to a painless or almost painless injection.

The administrator, bearing in mind that the hospital exists primarily for the welfare of the patient, is ready to co-operate with the medical staff by providing whatever is necessary for effective treatment.

This method presented no difficulty until penicillin prescriptions became increasingly more numerous, whereupon the established system proved cumbersome and unsatisfactory.

A comparative month by month study of the number of 100,000-unit vials, consumed for injection purposes, appears herewith.

To serve at all hours, day and night, to label and to charge as many as 1,663 vials such as was done in August, 1946, is no small task for the pharmacist, especially during the summer months when vacations are in force and help is limited.

As the demand for penicillin grew, charge and credit slips routinely forwarded from the pharmacy to the business office caused a perceptible increase in the clerical work as well.

The head nurses were obliged to make a tiresome daily check on all the penicillin being used in their respective departments, and to ensure proper refrigeration of the drug. They were also responsible for making certain that the unprecedentedly large number of intramuscular injections were given in correct dosage at the proper time. Because of constantly changing staff and rapid turnover of patients, it can readily be seen how exacting was their responsibility. These are only a few

	Jan.	*Feb.*	*Mar.*	*Apr.*	*May*	*June*	*July*	*Aug.*	*Sept.*	*Oct.*	*Nov.*	*Dec.*
1945.....	236	196	154	218	422	270	264	317	433	391	733	915
1946.....	878	1182	1314	1280	961	1038	1267	1663	1304	1875	1410	1550

ONE HOSPITAL'S EXPERIENCE

In the distribution and administration of penicillin in our institution we at first followed the procedure in current use for all other medications: i.e., single vials of 100,000 units were requisitioned from the pharmacist, labeled, dispensed to the department, dissolved by the nurse, and administered as needed. When a given vial had been exhausted, another was procured in the same way.

of the undesirable features of the original system.

Experiment Tried

After a few months of study, a plan of centralization was formulated and was put into effect May 30, 1946, in one department only, with bed capacity of 48. In this department, from 90 to as many as 110 injections were prescribed in one 24-hour period. A routine was set up, one nurse being delegated to handle all vials and syringes and to keep a record of injections in a special book. The plan worked well. Doctors, nurses and, especially, patients were relieved of much needless anxiety. The difficulty of providing a supply of syringes was greatly reduced by using one labeled syringe per patient for each 24-hour period, with sterile needles being supplied for each injection. We modified and improved this system from day to day until finally it was considered practical enough to warrant its application to all patients undergoing treatment in the entire hospital.

Organization

On October 7, 1946, the Penicillin Treatment Centre began to function as an organized unit. From that date, responsibility for procuring and administering penicillin throughout the hospital was supervised by one graduate nurse. The plan of organization is as follows:

1. The centre is located in the central supply room where a refrigerator has been installed for the storage of penicillin stock, syringes, trays, etc.

2. Vials containing 500,000 Oxford units of penicillin each are used exclusively.

3. Two sterile trays are set up for day and night use alternately, each containing the following supplies: (a) 5 cc. and 10 cc. syringes; (b) towels; (c) cotton balls; (d) No. 22 intramuscular needles in bulk (on compresses in a pleated towel); (e) No. 19 needles for dissolving penicillin.

4. Square-ruled record note-books are used as follows: (a) One in each department in which are listed the names and room numbers of all patients getting penicillin, with the dose and time-schedule copied daily from the chart by the head nurse; (b) one in the Penicillin Centre summarizing the information recorded in the department books.

5. The graduate nurse in charge of the central supply room instructs a senior student in the preparation of supplies and administration of injections.

6. The centralization plan operates on the principle that, with the approval of the medical staff, "semi-sterile" technique may be used in penicillin therapy.

Present Procedure and its Advantages

Economy: A 500,000-unit vial of concentrated solution is prepared by dissolving the vial in 10 cc. of solvent which yields 50,000 Oxford units of penicillin per cc. of solution; 12½ cc. of solvent yields 40,000 Oxford units per cc. of solution. Varying the amount of solvent in this way one can produce any strength of solution desired. A 12-hour dosage of penicillin for each patient can be drawn into a 5 cc. or 10 cc. syringe, thus permitting the injection of a fractional part of this supply for each individual dose, and the retention of the remainder for subsequent doses during that 12-hour period. Needles, of course, are changed after each injection. The 12-hour night supply can be prepared in the same way.

This concentrated solution provides an injection of lesser volume and thus causes a minimum of discomfort to the patient and takes less time to prepare. One 500,000-unit vial lasts five times as long as the 100,000-unit size. For instance, by investing in the 500,000-unit size, the 1,663 100,000-unit vials consumed in August, 1946, could have been reduced to 332 3/5 vials.

Syringes: The present system uses exactly one-eighth the number of syringes as compared with the former method. To illustrate—if 20 patients are receiving penicillin injections every 3 hours, a total of 8 doses per patient every 24 hours, 160 doses must be given. In that time, accord-

ing to the former system in which one syringe was required for each dose, 160 syringes would have been needed to give 160 doses. According to the present system, employing one syringe per patient per day, 20 syringes are needed to give the same 160 doses. Calculated for one week, we arrive at the following:

160 syringes per day x 7 equals 1,120 syringes per week; 20 syringes per day x 7 equals 140 syringes per week.

Using one-eighth the number of syringes has two distinct advantages: (1) Much less material to clean, sterilize, and store; (2) much less breakage. The syringes are put up in bulk to be sterilized in the Penicillin Set. No individual wrappers or containers are needed.

Needles: To dissolve and draw the penicillin, No. 19 needles are used; the No. 22 intramuscular needles are thereby not abused by insertion into rubber-stoppered vials. The needles are used by the same nurse who is trained to care for the equipment for which she is responsible.

Analgesia: With the use of No. 22 needles for injection purposes only, we have observed a marked reduction in requests for procaine or metycaine. Formerly 30 to 40 per cent of the patients on injection therapy received some form of local anesthetic with each dose of penicillin. At present, only .2 per cent of patients receive it.

Recommendations: Between doses, the syringes containing penicillin are stored on trays marked for each department in the refrigerator in the Penicillin Centre at 15°C. or below. Each tray is covered with a sterile towel. When not in use the syringe barrel is slightly elevated at the hub to prevent escape of the medication by gravity. If this last detail is not observed it is surprising how much penicillin can be wasted.

When making rounds to give injections the identical route should be followed invariably. This is important because of the time element involved in penicillin treatment.

The department penicillin books

Room	Patient	Dose in Units	Dose in cc.	Time Schedule													
				8	9	10	12	2	3	4	6	8	9	10	12	2	3	4	6
136	John Doe. . .	20,000 q.3.h.	½		D.D.		D.D.		D.D.		D.D.		N.P.		N.P.		N.P.		N.P.
324–2	Mary Jones.	50,000 q.4.h.	1			D.D.		D.D.			D.D.			disc.		—			—
425–1	Anna Brown	25,000 q.2.h.	½				started D.D.	D.R. D.D.			D.D.	D.D.	N.P.	N.P.	N.P.	N.P.		N.P.	N.P.

$x.xx Charge for medication (Does not vary)	Units per dose	Number of injections given	Charge per injection	Total charge to patient for treatment (varies)
800,000 units	100,000	8	$0.10	$x.xx plus .80
800,000 units	50,000	16	0.10	x.xx plus 1.60
800,000 units	25,000	32	0.10	x.xx plus 3.20
800,000 units	20,000	40	0.10	x.xx plus 4.00

should be kept in a uniform place in each department—e.g., the head nurse's desk. The nurse administering penicillin must strictly adhere to the practice of initialling the square under the time of dosage immediately after making rounds in each department. In this way the head nurse can see at a glance whether or not a patient has received the prescribed dose. The penicillin record book in the central supply room is also initialled for each dose but only after a complete series of doses has been given.

For obvious reasons, telephone messages from the head nurse of any department are accepted for "stat," "discontinued," or "changed" orders. But whether telephoned or not, all orders and changes must appear in the department penicillin book as soon as received.

Time schedule: The following time schedules were adopted by the Penicillin Treatment Centre:

Doses on a 2-hourly basis are given at 8:00, 10:00, 12:00, 2:00, 4:00, 6:00; doses on a 3-hourly basis are given at 9:00, 12:00, 3:00, 6:00; doses on a 4-hourly basis are given at 10:00, 2:00, 6:00.

Day doses are recorded and initialled in blue pencil. Night doses are recorded and initialled in red pencil.

Financial Aspects

Since the organization of the Penicillin Treatment Centre, there has been a marked reduction in the number of vials purchased by the pharmacist, resulting in one-fifth the amount of storage required. Instead of storing a 15-day supply of 24,945 vials the amount is now reduced to 4,989 vials.

The labeling and charging of this vast number of vials have been eliminated. The central supply room provides for a 24-hour supply, serves each dose from stock solution, charges per dose, and forwards the charge slips to the business office daily at 3:00 p.m. According to the above method, uniformity of charges is maintained for all patients.

A table of charges is used for billing patients and a nominal fee is charged for each injection.

Conclusion

The success of the Penicillin Treatment Centre indicates the practicability as well as economy of controlling the distribution and administration not only of penicillin but also of streptomycin and other medications given in divided intramuscular injections.

Credits

More than $8,000,000 in re-establishment credits was disbursed on behalf of ex-service men and women during the month of May, 1947, by D.V.A.'s Re-establishment Credit Division. The overall total of credits paid up to the end of May was $136,179,256, while the month's payments amounted to $8,151,266. Fifty-five per cent of all credit payments have been approved for the purchase of furniture and household equipment.

Training Nursing Assistants

DOROTHY G. RIDDELL

IN June, 1946, an inquiry was made by the Minister of Health into the problem of shortage of nursing personnel in hospitals in Ontario. Information was obtained from all hospitals with the exception of federal and private institutions. The widest possible expression of opinion was sought regarding methods which ought to be employed in solving the difficulty of securing adequate staff, by the question: "What suggestion can you offer toward a solution of the general problem?" The chief suggestion obtained was for the establishment of training schools and the provision for licensing of nursing assistants.*

The Minister, in July, called a meeting which was attended by representatives of the Registered Nurses Association of Ontario, the Ontario Medical Association, the Ontario Hospital Association, and the Department of Health. This committee approved the establishment of a nine-month course for the purpose of training nursing assistants under the provincial government. It recommended that certain hospitals might also conduct courses, provided they were established on a satisfactory basis. The committee suggested that an Advisory Committee of thirteen members be formed, upon the invitation of the Minister of Health.

The Department of Education had been interested, prior to this, in the Practical Nursing Course in the Canadian Vocational Training program. They expressed their interest in the Nursing Assistant Course too. As a result money was made available for the establishment and conduct of courses under the joint direction of the Departments of Health and Education, and the first courses began in September.

The first publicity was released to the press in August, 1946. Since then there have been periodic announcements in all papers about incoming classes. All hospitals in Ontario were asked to assist in obtaining suitable applicants. Information about the Nursing Assistant Course has been given to employment agencies, various organizations, vocational guidance counsellors, and on request. In December, 1946, the Advisory Committee recommended that the educational admission requirement be changed from Grade X to Grade VIII. The approval of the original committee was sought. It was deemed advisable to make this change since the enrolment without it was not sufficient to warrant the expense involved.

A careful selection of trainees is made by the Nurse Registration Branch. Wherever possible a personal interview is given. The admission requirements are:

Grade VIII education; medical certificate of good health; age limits of 18 to 40 years; letters of reference from a minister or priest, a citizen, a former school teacher, and a relative; an interest in nursing.

Applicants who are residents of Ontario are given a monthly allowance of sixty dollars and transportation is paid from the applicant's home to the Training Centres. A complete

Stud. Vets. Photo

The Anatomy Lesson

* "Statistical Survey in Nursing Personnel in Ontario, June 1946"— Medical Statistics Branch, Department of Health.

medical examination, including immunization, is given on admission to the course. Individual arrangements are made with each hospital for provision of medical care in case of illness. A terminal medical examination is given.

Uniforms are provided. The design has been carefully selected and the uniform is made to measure. It consists of an apple green one-piece dress, over which is worn a white apron designed on princess lines. Brown shoes and stockings are worn. At the end of the six-month course the trainee receives a cap. It is white with a green piping. After graduation and as long as she is employed in this type of work it is hoped that the nursing assistant will continue to wear this distinctive uniform.

The Departments of Education and Health shared in the organization of the course. The Department of Education has provided and equipped the three training centres under the Training and Re-establishment Institutes. They have made available to the training centres, secretarial and accounting staff and have provided additional teaching staff, such as part-time dietitians.

The Department of Health, Nurse Registration Branch, has appointed Miss N. Margaret Dulmage as inspector and supervisor of the Nursing Assistant Courses. Her responsibilities include the evaluation of hospitals seeking approval as training centres, supervision of the teaching staff, and the co-ordination of the training centres and selected hospitals. She will consider the objectives of the courses and will endeavor to set standards for this type of worker in hospitals.

N. Featherstone Cowley

MARGARET DULMAGE

The Training Centres are located in Hamilton, Kingston, and Toronto. They are attractively equipped. Each centre has a room for practical instruction in nursing, facilities for teaching cookery, classrooms, library, instructors' office, rest and recreation rooms. The Hamilton Centre is at the Training and Re-establishment Institute, Kenilworth Avenue North. The building was formerly an officers' mess. The Kingston Centre is located on the second storey of a fine stone building which was used for a business college. The address is 321 Queen Street. The Toronto Centre is at the Training and Re-establishment Institute Annex, 206 Huron Street. The instructors welcome visitors to their Centres for they are aware that their units are distinctive and well worth seeing.

The teaching staff at each Centre consists of a chief instructor, assistant instructor, and supervisors for the hospitals. The staff at present is:

Hamilton Centre: 2 instructors, 2 supervisors.

Kingston Centre: 2 instructors, 1 supervisor.

Toronto Centre: 2 instructors, 3 supervisors.

Members of the staff are experienced registered nurses. Four instructors have had a year's post-graduate course in supervision and teaching at a university. Five have had experience in the Armed Services. One has a university degree in Arts. All are keenly interested and aware of their responsibilities.

The syllabus, which has been prepared by the Registered Nurses Association of Ontario and which has been sent out to all hospitals in Ontario as a guide in training sub-

Student Veterans Photo, T.R.I.T.

Learning to take T.P.R.

sidiary workers, is the basis on which the course is planned. During the first three months, the trainees receive lectures in nursing and in the structure and function of the human body. There is also instruction in nutrition, personal hygiene, ethics, and housekeeping. Much is required of the teaching staff in the way of individual help, drill, and use of visuals aids. The trainees' experience is broadened by planned trips to a dairy, library, day nursery, and visits to special hospitals.

The program for clinical experience consists of three months in a hospital for the chronically ill and three months in a general or children's hospital. Arrangements are now being made at the Orillia Hospital for Mentally Defective Children for trainees to have some experience in the pediatric wards of the hospital. The hospitals are carefully chosen and arrangements are made on an individual basis. The nursing assistant supervisor in the hospital is responsible for the supervision of the work of the trainees, ward talks, and a few records. She is responsible to the head nurse for the nursing care of the patients under her supervision. In the care of the chronically ill there is a real adjustment for the young trainee who has never been in a hospital before.

The Training Centres are open five days a week from 8:30 to 4:30 p.m. Trainees in the hospital are on duty eight hours a day, six days a week. They spend about one week on afternoon and night shift each, in order to acquaint themselves with the twenty-four hour period of duty.

Departmental examinations are set for nursing assistants. A policy-forming committee has been made up of instructors of approved schools of nursing in Ontario, and representatives from the Departments of Education and Health. Examinations are set and marked by a board of examiners selected from the nursing assistant teaching staff. The present plan for the qualifying examination consists of one paper, objective type, covering the course of studies. The practical mark is based on the reports of the instructors and supervisors during the nine months' training, and represents 60 per cent of the passing grade. The supervisor, Nurse Registration Branch,

Stud. Vets. Photo

Bathing a Baby

may request a practical demonstration in cases where she considers it advisable.

The supervisor interviews each applicant who makes a personal application, and during the course talks to trainees who have problems. In the last month of training each young woman is interviewed again to discuss employment opportunities. Nursing assistants are advised to work under supervision in a hospital or organization in their own community.

On successful completion of the course the graduate is given a certificate and is known as a Certified Nursing Assistant, as provided for by the Nurses' Act 1947.

Letters have been sent to all superintendents of hospitals as to the numbers of trainees available for employment with an outline of the instruction given. Suggestions have been made about salaries. It is pointed out again that the nursing assistant is not a substitute for the graduate nurse and that the function of the nursing assistant is to assist in the nursing care of patients. Many hospitals are welcoming the subsidiary worker on their staff.

The Registered Nurses Association recently requested all superintendents of nurses to recruit applicants locally, to encourage them to take the course, and to offer employment on the successful completion of it. Classes begin each January, April, and September. In the September, 1947, class more than one hundred young women entered training to become nursing assistants.

Eleven months after the inception of the course, under the government plan, figures are as follows:

Enrolled — 235; discontinued — 59; graduated — 52; still in school — 124.

Of the 59 trainees who have discontinued the course, 17 left for health reasons, 14 did not meet the academic standards of the school, 28 left for other reasons, such as marriage, family responsibilities, etc. The number enrolled to date represent 59 communities in Ontario.

Two hospital centres have been approved for the training of nursing assistants. They are located at Picton and Hamilton Sanatorium. Graduates of these courses are eligible to write Departmental examinations and may become certified.

The co-operation of all participating in the course has been an important factor in the progress made to date. The success of the Nursing Assistant Training Course can only be measured by the quality of nursing care given to the public, and to the extent that the numbers who graduate will help meet the demand for nursing personnel.

Health cannot be given to the community by laws, motion pictures, offering advice, or fining those who fail to report disease. The patient, the community, can be as healthy as it chooses or as sick as it is willing to stand for. Only when the community fully understands the reasons for these things will it take an active interest in public health work.

—HAVEN EMERSON, M.D.

German medicine, once among the finest in the world, has fallen to an almost unbelievably low estate. The load of patients is greater than ever before. Many of the hospitals and laboratories are in ruins. Some of the foremost physicians and medical scientists, closely associated with the Nazi regime, still are in concentration camps.

—*News Notes No. 63*

Trends in Nursing

ELEANOR MACINTOSH, B.Sc.

THE NEWSPAPER headlines describing social conditions prevailing today are most disturbing. If utter confusion of thought has dominated the world at any time since the Tower of Babel, it is now. At this crucial time, we of the nursing profession have a serious and worthwhile part to play in trying to turn this chaos into order. To accomplish this we must first evaluate what has been accomplished in nursing and our own professional strengths and weaknesses. Then we must analyze the present nursing trends to see where they will lead if we follow, to determine which should be kept and made stronger, and which should be changed or eliminated.

A span of about seventy years has elapsed since the first schools of nursing were established on this continent. During this time our nursing history has passed rather rapidly from the early "pioneering" years and the "boom" days to the age of "stock-taking" and attempted reform; and recently from the emergency years of World War II to the present period. We are at the "eve of the unknown" in our profession — a time for instituting a broad educational program which will adequately serve professional, community, and individual needs. Before defining such a program it is essential that we question our philosophy of education. According to the *Supplement to the Proposed Curriculum for Schools of Nursing in Canada*, "a philosophy of education implies a point of view or attitude towards life, and a belief in what education can contribute to the fulfilment of its highest purpose." What is our characteristic attitude toward education and its problems? Is our dominant attitude conservative — opposed to change, steeped in tradition and skeptical of new ideas, or is it liberal — inclined towards experimentation and reasonably hospitable to new ideas? To be dynamic, our educational plan must be built on a philosophy which is capable of change and expansion, vision and foresight.

THE AIMS OF NURSING

The traditional aims of nursing education have been "unquestioning obedience, self-sacrifice, practical utility and technical efficiency." Both science and society are making revolutionary changes today. If we are to prepare nurses to cope with these changes, we must modify our traditional aims so that our discipline will stimulate rather than stultify initiative and self-direction; our self-sacrifice must provide for personal as well as professional growth; and our technical efficiency must be that of a "thinking" person, not an automaton.

The essentials today are *knowledge* of such activities as will help patients to regain and maintain health; *abilities* to solve nursing problems and to evaluate results; a *comprehension* of the "why" as well as the "how" of hospital techniques; and the satisfactory *application* of health knowledge and nursing service for individuals of all ages in sickness and in health, regardless of race, creed, or economic status. The attainment of these aims in the "World of Tomorrow" can be effected only by stressing the need of *adjustment*.

What a person "is" is as important as what a person "does." Therefore, nurse educators must aim at developing well-adjusted women who will be intelligent citizens as well as skilful technicians, and who will be happy in personal as well as professional life. We must no longer subordinate the "human" element of our teaching to physical and technical efficiency.

From young and old — from right-wingers and left-wingers — questions pelt with great force about the aims of modern nursing education. Some, timid and skeptical, ask, "Are not

these modern ideals too high to be attained?" Some who sense a challenge ask, "How may we fulfil these aims?" Others clinging to tradition say, "Is not self-sacrifice an indispensable requisite of a good nurse?" And then comes the spectre question, "Why is the graduate of today so inferior to the graduate of yesterday?"

Let us challenge this last question with another! What standards are being used to compare and measure the nurse of 1947 with the graduate of 1937? If the former is inferior, is it the fault of the individual nurse, of society, or of the present-day educational system? Is it the fault of the nurse-leaders who are doing the educating? Have there not always been the "good" nurses and the "poor" nurses? Are there not nurses who graduated yesterday — nurses who consider themselves in "good standing"— who exhibit some of the same failings which we criticize in the young nurses of today?

It is not difficult to list these failings for they run the whole gamut of human frailties as they appear in our professional nurses: lack of attention to the professional requirements of uniform, on duty or on the street; thoughtlessness in conversation before students concerning hospital administration; unethical relationships with students; unprofessional shortcuts in nursing procedures; non-support of nursing organizations by lack of attendance at meetings or failure to subscribe to official magazines; leaving the reading of professional literature to a "more convenient time."

Difficulties in personal adjustments loom up spectacularly sacrificing leisure activities and friendships to over-application to work; intolerance for human weaknesses; racial and class prejudices; and gross failures in the practice of physical and mental health teaching. It is so easy to do destructive thinking, and very difficult to do creative thinking; so easy to conceal our ideas in the guise of chronic complaints, muttered weakly behind closed doors; very difficult to place carefully thought-out suggestions before the proper authorities. It is easy to listen to rumor and gossip, but very difficult to follow rumor to its source and know the truth of the story. Until we oldsters in the profession can truthfully say that we are free from these weaknesses, it is neither safe nor expedient to assert the superiority or the inferiority of either professional age level or of either system of training — traditional or modern. We who offer ourselves for positions as nurse educators make ourselves subject to all professional ethics and adjustments—we must teach by example as well as by precept. So long as we flagrantly disregard any requirement — even the least of these presented to the students as being essential — we are neither being honest nor conscientious in our endeavor to make modern nursing education successful.

Preparing Leaders

The trend toward preparing better leaders for the students of today is important. Provision for full-time study or part-time work at universities has been made. If the savings of a graduate do not permit this expenditure, financial aid is available. Needs for well-trained administrators, instructors, supervisors, and head nurses are increasing steadily. The value of qualified leaders — qualified in personality as well as in technical perfection — is becoming fully recognized. Environmental factors, such as poor health and fatigue, enter into the picture we often see of our capped students — discontent, discouragement, boredom, even open resentment.

Too often, however, students feel inward rebellion against leaders. Personalities are pitted against personalities with resulting feelings and attitudes disguised by disinterest and resentment. Students must have confidence and respect for the judgment and integrity of those who are evaluating their work and guiding them. With an adviser who is over-dictatorial and over-critical — more like a foreman than a teacher — or with a leader who is lackadaisical and indifferent, or intolerant of human weaknesses, nursing pays the

penalty in loss of motivation. Leaders in general education today are attempting to teach adolescents to be self-reliant, to develop sound philosophies of life, and to have an adult point of view as they face their chosen career. Have we subordinated this type of teaching to a militaristic way of training those who come under our influence? Are we reaping bitterness and conflict because of this? We must find a middle road for leaders of nursing. Perhaps the sign-board leading to this middle road will be in the preparation of better adjusted individuals who will be our nurse-educators of the future.

Curriculum Planning

In planning our curriculum today, our yardstick for accomplishment is maintenance of health, whereas less than half a century ago it was the decrease of mortality. It is a rare artist who creates without appreciation, knowledge, and technique of practice. So it is the rare nurse who comprehends her responsibilities as a nurse, a woman and a citizen without opportunities as a student to broaden her philosophical concepts, increase her social knowledge, and practice techniques in the light of modern science. A knowledge of the preventive aspects of disease and the social aspects of life are equally important. Our curriculum must provide for mental hygiene so that nearly one-half the ailments which invalid the human race may be prevented. How varied a nurse's knowledge must be today is easily recognized when we see the remarkable potencies of the new chemotherapy, penicillin, streptomycin, of such biological products as Gamma globulin, and of serums against the degenerative diseases.

With the progress of public health in eliminating the communicable disease menace, a new set of problems arise — those involving the average age level of the population. Hence, a knowledge of the diseases relating to later years becomes most important. In the world of the future, the child will be the vital asset; so we must integrate into our curriculum planning for the intelligent cultivation of this child of tomorrow. This means a study of the normal child as well as the abnormal child. Since the nurse's responsibility is shifting so rapidly to public health service — hospital service was the sole goal for years — public health in all its aspects must be part of our standard curriculum. A knowledge of community life, of family life, and all the social relationships involved becomes vitally important. With the increase in scientific knowledge, and with the complexity of techniques advancing to correspond with the strides of modern medicine, the length of our course in nursing education remains the same as when nursing was less complicated. We sacrifice our students to servicing the hospitals instead of giving them time to learn — yet we call ourselves educators.

Frequently our hospitals and schools are inadequately staffed with qualified personnel. Should there be a sufficient number of specialists, they are often delegated to such tasks as conducting post-graduate or refresher courses. The training of our students in such instances becomes secondary. Students are permitted to repeat simple procedures thousands of times thus allowing the monotony of routine to dampen enthusiasm and to lessen thoughtful action. This in turn results in cynical attitudes and the tendency to follow routine without active intelligence.

Students enter schools of nursing because they wish to *learn* how to serve, yet these novices are disillusioned at the very start because they see their value in service placed before their learning. We have all seen it happen — students foregoing attendance at ward teaching programs because of busy ward routines; students rushing to class late or, if on time, coming with the worries of unfinished ward assignments on their minds.

The modern trend is to staff with a sufficient number of general staff nurses so that the requirements for service by students are materially lessened; to decrease the hours

on night duty and provide for a more balanced day of learning and "living." There is also a move toward providing a greater number of clinical instructors; of having classroom instructors specialists rather than one who has a smattering in nine or ten subjects and is an authority on none. The clerical staff will, moreover, be increased to take over the "book work" with which the present-day head nurse and administrator is overburdened.

Pre-Nursing Tests

Elevating the standards of curriculum requirements and passing levels are constantly being discussed. We often expect a superhuman professional nurse to be produced, but frequently we are not considering the ability of the specific person considered. Do we know the specific abilities under our present testing systems? Can we rely on the recommendations we are now receiving concerning our applicants? Do the people who are doing the recommending really know what nursing education is, and the abilities it requires? Perhaps many heart-breaks on the part of educators, schools, hospitals, and the unfortunate individuals themselves could be avoided if there were a system which classified students in the beginning, and trained them for their specific category rather than give the same training to all. Would this not put an end to the neglect of the bright student by the instructor who is duty-bound to try to pull the less capable student up to a passing grade? No school wishes to be represented by poor nurses; yet, how many mediocre professional nurses are graduated — so mediocre that even the home school avoids employing them. These people go out not only as typical members of a particular school but as typical representatives of our profession.

Pre-nursing tests administered and read by experts are becoming more popular. These tests serve as valuable tools in the selection of students as well as a basis for guidance after enrolment. Through proper guidance a student may be helped to make a more expeditious and favourable adjustment to nursing. Through careful screening and selection, by early and effective guidance, good professional material may be discovered and proper cultivation administered. Such guidance, as is given in a pre-testing service, saves the applicant, who is low in ability and incapable of meeting requirements, disappointment, disillusionment, bitterness, time and money; the interests of society are safeguarded against inefficient practitioners; and the nurse-educators and schools are saved the expense and unfruitful — even wasteful — use of time and resources. It is important to discriminate adequately between those who show promise and those who do not.

Some definite conclusions have been reached by those who are making testing their life work. One such conclusion is that any grading system, allowing for a more or less decisive and unreasoned grading by an individual with the results expressed in a fixed per cent, without taking into consideration the distribution of the scores, is unsatisfactory and unreliable. The better systems are those which determine the placement of the score by its relation to the average ability of the group involved, and the degree of variability of the individual from the average. This does away with group results in which there are no grades above D, or no grades below B. Test results often depend as much upon the teacher as upon the students; faulty instruction must be considered on a level with student ability. Each institution prides itself on the best selection of the finest applicants available; therefore, if we have the best ability that is available for our profession, it behooves us to wonder if our present grading systems are fair or if our own failures as teachers are being considered when our student groups fail to achieve a good distribution of grades.

Importance of Health

We who are guiding students realize that good health is not a

fixed characteristic — it must be improved. Sunshine and physical activities are imperative. Classes, long hours of study, and ward service keep the student within doors during the daylight hours. This lowers both mental and physical resistance. What is the result? A restless, mentally depressed, physically weakened individual. The accepted cure or prevention is a social program that offers activities during all the hours of the day. This will often change a student from a liability to an asset. The schools of the future will employ social directors who will plan such activities as will be refreshing, mentally and physically, for each student, with these activities made available to resident graduates as well as to students. This planned program may prevent the psychological slump that is epidemic among students in nursing. Opportunities for hobbies, with instruction; organization of clubs, space for romping, with shouting; archery, tennis, horseback riding, all within the school — to these our students of the future may look forward.

A Changing World

In the twentieth century there have been two wars involving the greater portion of mankind. Out of their turmoil there has developed a cognizance of a constantly changing world, threatening a revolution of our entire social structure. Nurses are concerned with all sides of the question. It is with this in mind that modern nursing education seeks to stimulate health-thinking in the minds of the general population. Already the size of this "thinking group" of the general public has increased beyond the imagination of our forefathers. This accelerated interest is due to mass educational movements, scientific advancements, improved means of communication and transportation, and the hope of better living. These higher standards of living for all are based on democratic ideals. Emphasis is being placed on better housing, slum clearance, better nutrition for all; health regulations which will provide prepayment plans for all health emergencies; building of community institutions for the aged, the chronically ill, and the convalescents; and the organization of community health councils that will plan a family health program, recognizing what each profession can offer on a co-operative basis.

Nurses must be prepared, as citizens, to participate in such programs for this concept of co-ordinating community agencies and resources is permeating the thinking of various parts of the country at this time. Regardless of whether we live in a nursing institution or out in the community, we are still a part of the community and we are citizens. Our relationship with the public is especially important. It is surprising how many people are still so uninformed about one of the country's most vital professions. It is for us to see that all these people are equipped with the knowledge and understanding of our profession. The trend is toward local professional organizations launching campaigns to overcome the prevalent negative attitude and apathy about nursing. Individual nurses themselves must become more active in the community.

The Human Element

The question of the necessity for absolute, complete personal sacrifice is a vital one today. It is keeping many desirable applicants from the nursing profession. The nursing profession cannot continue to exist if the idea of sacrificing all personal interests to professional duty persists. Our mental hygienists and our psychiatrists say that fewer beds would be occupied in institutions for the mentally ill if it were not for fanaticisms of one kind or another. No other profession expects such a type of self-sacrifice. We are a teaching profession — teaching preventive medicine. Can we teach successfully if we are not living examples of the theories presented? Unreasoned enthusiasm and uncontrolled zest for perfection and self-sacrifice break

physical and mental health and warp personalities. This unharnessed fervor starves those who would like to contribute creative thinking but are forced to be onlookers by the overzealous.

Normal youth today wishes to live a well-rounded and a complete life. Nurses are normal, not abnormal, in desiring a balanced life, professional interests and work, time for religious growth, community and citizenship responsibilities, and personal relationships. The question which must be answered is: shall we permit interested, desirable young women, with ability to train and serve as nurses, to be lost to our profession — to go to other professions — when our own needs them so vitally? Shall we, who are already in the profession transfer to other professions because we cannot agree with the "total self-sacrifice" requirements of many administrators? We have not lost the desire to serve, nor the willingness to attain sufficient education to carry on advancements in nursing.

Out of all these problems has come the need for adequate personnel administration and counselling, the object of which is to hold efficient nurses and administrators and to secure such students as will become desirable representatives of our profession. Our nursing service must be effectively conducted and constantly improved. Sound personnel administration is good business policy; it reaps great benefits in the end.

Personnel practices are becoming so essential that college courses are being devoted to this subject, and nurses are specializing in the field of guidance or counselling of both graduates and students. All who are potential teachers should realize their responsibility to consider the student as a whole. "The student is as important as what the student does." The personnel point of view puts emphasis upon this factor, adapting college methods to the solution of problems faced. This opens a new field for nurses of the future — the trained counsellor.

Only a few of the trends of modern nursing education have been discussed here. Space does not permit discussion of the role of the university schools of nursing in our present-day planning. The accreditation of schools of nursing is another forward-looking step which is in the offing. There is a quotation from long ago: "If a man have a garden in which there are poisonous serpents and beautiful flowers, he must first deal with the serpents before he can enjoy the flowers." Let us eradicate the poisonous serpents in our professional garden by facing and accepting the fact that improvement can and must be made, rather than being of the group who curse the darkness. Let us take appropriate action and, if our end results sometimes are unsuccessful, let us remember the adage: "Man's tower of strength is in his mistakes — the man who really succeeds in life is the man who is willing to begin again."

Hepatitis Research

A laboratory for the study of infectious hepatitis has been set up at the University of Heidelberg. The causative organism and method of transmission of hepatitis, which first attracted wide attention during the war, thus far have defied detection. It is a malady characterized by fever, nausea, and abdominal disturbances—usually accompanied by the yellow color associated with jaundice.

Thus far it has been established that it is due to a filterable virus. The virus itself has not been isolated. It has not been possible to find any experimental animal which is subject to the malady. The virus is known to be extremely infective, but there is no agreement as to how the disease is spread or as to its incubation period. There is some evidence that the virus is spread from person to person in water. There also is some reason to believe that the disease is much more common than generally supposed and that it often appears, like the better known poliomyelitis, in a subclinical form which is not recognized by the victim. —*News Notes No. 63*

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

The Public Health Nurse and Mental Hygiene

CHARLES H. GUNDRY, M.D.

THE PUBLIC HEALTH nurses have become a great influence for general education about matters affecting health by the persistent application of a simple principle. People are interested in learning about matters that touch their own lives closely and may understand in a general way that vaccination and the use of cod liver oil are considered to be valuable for the protection of health, and still neglect to apply the knowledge because of a sort of inertia and a comfortable ostrich-like feeling that smallpox and rickets are remote troubles that might bother people in less favored places but couldn't strike their own families. The public health nurse does two things to overcome this sort of isolationism. In the first place she appeals to children and their parents on the basis of friendship. She knows them personally and brings information about good health practices to them in informal personal chats which can be much more persuasive than impersonal printed material or mass instruction by radio. In the second place she shows them how measures designed to protect and promote good health apply to them personally.

The campaign to popularize the use of cod liver oil has been pretty well won. Now there is a very lively interest in mental illnesses and personality difficulties. Magazines and movies devote a good deal of attention to these topics. People are more open to information about psychiatric subjects than they ever were before. Until very recently the general attitudes towards any "mental trouble" were to consider it as a family skeleton to be well hidden or to camouflage it as a "decline" or "breakdown" or sometimes to parade it as a mark of distinction genteelly called "nervousness." Certainly there is a growing tendency to be more open-minded and realistic about emotional and mental problems.

Psychiatric disabilities of all sorts are very prevalent and they bring grievous personal suffering and great financial expense. They constitute one of the great public health problems. The public health nurses are trying to do their share towards the prevention of these illnesses by applying the same methods of individual friendly teaching that seem to have been effective in other fields.

There are good grounds for thinking that this approach should be effective in helping to prevent psychiatric disorders. Severe mental diseases, definite neuroses, and disabling disorders of personality do not develop suddenly as a rule, though the obvious onset of an episode may

be acute. The onset of an acute phase of a psychiatric illness may be related to some stress or difficulty affecting a person just at the time of his illness. However, as well as the seed there is always the soil. It is not possible to make life free from difficulties and emotional conflicts but it is possible to make the soil, which is individual personality and group morale, very inhospitable to the seeds of mental illness. The preparation of the soil for that purpose must begin in infancy. It requires that babies and infants be given a sense of emotional security, that they be loved wisely and treated as if they were important individuals in a family democracy where each member is important. It does not require that they be allowed to become domestic tyrants at two years of age. It requires that the divine individuality of each child be encouraged to develop. Children differ in many ways — physically, intellectually, and temperamentally. It is the ways in which they differ that make children most appealing and adults most creative. Obviously, individualism run amuck would make social living altogether too exciting and would be wasteful, but there is much evidence that restraints and inhibitions, too arbitrarily imposed, can have just as dangerous consequences. For instance, aggressiveness in children must be controlled and the control of crude infantile aggressive behavior has always been one of the main aims of traditional methods of child training. That aim is not open to criticism, but often the methods and results are. If a child is brought up so that he finds outlets for his aggressiveness, first in opportunities for a moderate amount of self-expression in competition with other children and, later, in striving for the common good, and for competence in his own work, then he will probably have satisfactory stability and be easy to get along with. If the attempt is made to repress all expression of aggressiveness on the other hand the result is likely to be development of one of two extremes of personality — the "milk-toast" type with neurotic symptoms or the aggressive impulsive person always throwing monkey-wrenches into the machinery. The requirement for good mental health is that each child be trained to adequate social conformity and self-discipline by example and by consistent methods adjusted to his individual ability, temperament, and state of maturity. Over-protection and pampering can be considered in the same way. Good mental health demands adequate independence and sense of responsibility. Over-protection is poor preparation for independence but pushing a fledgling out of the nest too soon may make him permanently frightened for life. The child's "toughening-up" for life must be done by suitable degrees.

It is by attention to general principles such as these that the nurture of children should be guided if they are to develop personalities that will be poor soil for mental illness.

In her daily work the public health nurse meets many situations in which she has opportunities to apply these general principles to individual cases. She may be confronted with an example of symptoms caused by fear in an over-protected child. She can either encourage the symptoms by showing concern or she can reassure the child by encouraging him and helping him to face his problem. She can discuss the situation with the teacher and parents and persuade them to follow the same policy. That sort of treatment may be called just common sense but common sense is often aided a lot by special knowledge and a scientific attitude. The sort of special knowledge that applies to problems of emotional adjustment and development can be called the Principles of Mental Hygiene. The public health nurse cannot do her day's work properly if she neglects these principles and it is in their broad application that the hope of making the soil resistant to mental illness lies.

A good laugh and a long sleep are the best cures in the doctor's book.—*Irish Proverb*

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Personnel Guidance

C. E. M. Rowles

In the field of business and industry today, the emphasis is on efficiency, and the ability to produce the greatest turnover in the least possible time. Many factors enter into this process, and not the least is the placement of personnel, particularly when the more responsible positions are vacant.

It has always been desirable that round pegs shall be fitted into round holes, and square pegs into square; but this rarely happens as the result of chance. As in the game where one is required to manoeuvre a number of little balls into a corresponding number of holes, so, in the placing of personnel, considerable skill is needed on the part of those responsible for selection.

The personnel manager of the business world is obliged to study his candidates from various angles. He has on his list applicants of many types, with radical differences of education, race, religion, background, and physical aptitudes. Often it is necessary that the individual be tried in several departments before his niche is found, and this is achieved by co-operation and discussion between various heads of departments. Not only is it necessary for the business or industry in question that each person be in a position to give of his best, it is also necessary for the individual to be placed in work he can do well, and which he enjoys doing, if he is to be an active happy member of society.

When the above rules are applied to nursing it is found that different conditions obtain. For example, although we are dealing with individuals who have various personal differences, yet we are also dealing with a group which has a certain similarity of background, education, and interests, often to the exclusion of outside influences. The fact that prospective nurses spend three years of their professional life within the walls of an institution, subjected to more or less stringent rules, results in the production of individuals who are more of a pattern than would be found in other groups, from the viewpoint of the personnel manager. Again, the period of training, while excellent from the professional viewpoint, has often done nothing to prepare the young nurse for her place in the world of affairs, with the result that, at the end of three years of sheltered life, she is suddenly plunged into a world where she has to stand on her own feet in competition with others.

The day has gone by when three years of basic training prepared a nurse for a lifetime's career. With the day of specialization upon us, we realize that the problem of personnel placement and guidance is with us to stay. Nursing also has changed, in that many fields are now open to the young graduate, which were unknown a few years ago. In spite of the avenues ahead of them, it is surprising how often a nurse

is found in a position which does not satisfy her, and which fails to give full expression for her aptitudes. The answer often lies in the fact that many nurses do not realize the scope of their profession; and others do not know how to prepare and apply for desirable and congenial positions.

That something concrete must be done about this problem is all too evident, and in many provinces and districts steps are being taken to provide some form of personnel guidance. Through this medium, many nurses have been guided into more suitable occupation, and have been encouraged to train for advanced and congenial work.

There are two main avenues along which personnel guidance may develop. The first is in the school of nursing where, during the third year of her training, the student nurse receives a course of "Professional Problems and Modern Trends in Nursing." Here it is possible to widen the viewpoint of the individual, and to provide her with a working knowledge of nursing as it exists in Canada today. It is a fact that all too many nurses are ignorant of the opportunities within their profession and, what is more deplorable, many lack the proper knowledge of Canadian nursing legislation.

At present, the majority of young graduates find employment waiting on the doorstep on the day of graduation. Unfortunately, it is often present in such variety that it is easy for selection to be made on a financial basis, rather than on the basis of congenial work, acquired experience, and satisfied instincts.

Through the members of the teaching staff, valuable guidance of personnel may be given. It is possible, through lectures and discussions, to make the nursing world more vivid to the students in training, and to guide them to the work for which they are best suited. Nobody knows the individual student as does her instructor, and personal interviews during the senior year help to clarify in the student's mind her confused thoughts of the future. More preparation for the post-graduate world, with skilled direction, is needed by all young people venturing forth from institutions of learning, and particularly is this so in the case of young nurses who are called upon to take responsibilities far greater than those assumed by others of the same age group.

With the present demand for nurses it is often found that many members of the graduating class are re-absorbed into the hospital staff, usually as general staff nurses, sometimes as head nurses. In these cases it should be the aim of the director of nursing to see that these young women are not allowed to settle into a rut, even though that may be a tempting thought when one knows not whence the next nurse is coming. Often the nurse in question is not satisfied with her job, and does not know why. It may be something easily remedied, such as a transfer to another department or a change of shift; or it may be that the nurse has ambitions for more advanced work, but cannot see how she will ever be able to prepare for it.

Personal interviews, conferences, and staff education will give each nurse the opportunity to decide for herself what type of work she prefers. Experience may be found close at hand, or it may be necessary for her to study at a distant university. Whatever the outcome may be, the member of the staff, who is acting in the capacity of adviser, must herself be well informed and capable of giving helpful and practical advice to others.

By this means many young nurses may be guided into more congenial positions, and others stimulated to prepare themselves for such positions by advanced study. Often it is necessary that financial aid be obtained before university courses are taken, and here the adviser may bring to the attention of the nurse various bursaries and scholarships that are now available. Sometimes we find that the nurse is reluctant to apply because she feels that she has no chance of success; and sometimes she

is uncertain how to submit an application. The wise director is on hand to advise, help, and encourage.

The alternative pattern in this work is planned for the older group of graduate nurses. In some of the provinces, placement bureaux are playing an important part in personnel guidance. Through the medium of the bureau, which acts as an impersonal agent between employer and employee, many nurses are finding the positions they have always wanted, and directors of nursing service are able to fill vacant positions with suitable candidates.

The director of the bureau has an arduous task, especially as so much of the placement has to be done by correspondence, rather than by personal interview. Even where the interview is possible, it is often difficult in the short time available to assess the individual's merits justly and impartially, and more difficult to remember the facts clearly. The nurse's file, containing personal data, references, and details of training, experience, etc., should prove to be an invaluable aid in placing the applicant; but it does not provide that insight into character which is essential.

Where the placement bureau serves a city and its environs, it is often possible for personal interviews to be arranged with all applicants. This gives the director a more complete picture of the nurse who is seeking employment, especially if that director is a person of insight, capable of seeing beyond the tremors of a nervous applicant. It is not always possible for the director to go to the nurses of her district, but they should be encouraged to come to her, and to know her as a friend. References, although valuable, tend to be formal and non-informative and, when provided by friends, are not always to be relied upon. Therefore, it seems that the director of the placement bureau should be provided with ample time and opportunity to judge her applicants, if she is to guide them efficiently.

At this time when unemployment is unknown among nurses, it might seem that this plea for personnel guidance is unnecessary, but how much better if we could say that all nurses are employed in the positions best suited to them, rather than the bald statement: "All nurses are employed."

In Memoriam

Hazel (Darker) Buckland, who graduated from the Sherbrooke Hospital in 1925, passed away recently at Island Brook, Que.

Agnes Coburn passed away in London, Ont.

Lylian Audrey (Hurd) Knowles, who graduated from the Saskatoon City Hospital in 1928, died in July, 1947.

Christy A. MacKay, who was one of the first graduates of the Montreal General Hospital, died on July 28, 1947, in her ninetieth year. Miss MacKay spent most of her active years in the nursing profession in Montreal. She spent several months overseas as a private nurse to Lord Strathcona.

Edith McCausland, a graduate of Victoria Hospital, London, Ont., died there in July, 1947, after an illness of five months.

Velma (Coote) Morkill, who graduated from Sherbrooke Hospital in 1935, died in Megantic in her thirty-fifth year.

Eva A. Ross, aged thirty-five, a graduate of Soldiers' Memorial Hospital, Orillia, Ont., passed away following an operation. For some time Miss Ross had been employed as an office nurse in North Bay, Ont.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

L'Enseignement Chez les Malades

SUZANNE GIROUX

DANS les recommandations faites par l'Association des Infirmières du Canada sur le choix d'une bonne école d'infirmières, on lit: "Il est absolument nécessaire que les heures d'enseignement pratique dans les salles soient faites sous surveillance. Cet enseignement doit comprendre des conférences, des cliniques aux lits des malades, et de l'enseignement particulier. Cet enseignement doit être donné par des institutrices."

Si l'on veut être sincère l'on conviendra que les heures de travail sur les étages ne peuvent être considérées comme de l'enseignement pratique, à moins qu'une institutrice ou plus, selon le nombre d'élèves, enseigne aux élèves, en plus de bien travailler, l'application de ce qu'elles ont appris en classe, qu'elle les aide à mieux observer, à mieux analyser, à mieux comprendre le malade. Il faut que le travail sur les étages "soit une série d'expériences progressives tellement *contrôlées*, *reliées* entre elles et *unifiées* que ce que l'on apprend d'une expérience serve à l'interprétation, à l'agrandissement, et à l'enrichissement des expériences qui viendront par la suite." En d'autres mots, une expérience nouvelle doit faire appel à toutes les expériences passées (enseignement théorique, histoire de cas, malades traités) pouvant aider à mener à bonne fin cette nouvelle expérience.

Si l'on veut être sincère, l'on conviendra également qu'il est impossible de demander à l'hospitalière, qui a l'administration et la surveillance du département, de donner cet enseignement. Il est d'ailleurs démontré que si l'on veut que cet enseignement soit donné avec succès, que l'on ne doit pas demander à l'infirmière, qui est obligée de faire exécuter le travail du département, de donner cet enseignement. Son intérêt serait divisé entre les besoins du service et les besoins de l'école.

En plus, cet enseignement chez les malades doit être donné par une institutrice de carrière. L'hospitalière doit prendre part à cet enseignement en co-opérant étroitement avec l'institutrice, en aidant à la préparation et à l'exécution du programme.

Une fois convaincu de la nécessité et de l'urgence de l'enseignement chez les malades, la première chose à faire est de nommer une infirmière en charge de cet enseignement.

CHOIX DE LA DIRECTRICE DU PROGRAMME

Cette infirmière devra être convaincue de la valeur d'enseignement clinique. Elle doit être une institutrice ayant une certaine expérience dans l'enseignement. Son travail sera d'enseigner, soit en donnant des cliniques, des démonstrations dans divers départements, soit en observant l'enseignement donné par l'hospitalière, son assistante, et les autres infirmières diplômées. Il ne faut pas oublier que l'enseignement par l'exemple a toujours une grande valeur.

PROGRAMME

Le programme devra être préparé par la directrice des études et l'infirmière en charge de l'enseignement chez les malades, puis présenté aux

hospitalières pour étude. Une fois le programme corrigé et adopté, il doit être exécuté. Le but que l'on se propose doit être bien défini, rien de vague, comme une meilleure formation de l'infirmière, etc.

Chacune doit prendre part à l'exécution de ce programme — institutrices à l'école, hospitalières, infirmières diplômées, élèves, travailleuses sociales, etc. L'enseignement doit être démocratique, chacune peut dire son mot, apporter son idée.

Inutile de vous dire qu'il doit y avoir suffisamment de malades et de cas variés.

Le personnel de l'étage doit être suffisant pour permettre à un groupe d'élèves de se retirer dans une petite salle, un salarium, contenant des chaises, un tableau et discuter sur les malades qu'elles viennent d'observer, sur la solution qu'elles viennent de préparer, sur la cause sociale indirectement responsable de l'état de ce malade, sur quels moyens psychologiques à employer pour avoir la co-opération de ce malade, etc.

Durée du Cours

Dans son manuel sur l'enseignement chez les malades (Ward Teaching by Anna M. Taylor: J. B. Lippincott Co., 2083 rue Guy, Montréal) il est dit que les cours devraient être de 2½ heures par semaine, donnés soit en cinq périodes d'une ½ heure, ou encore en trois périodes d'une ½ heure et trois de vingt minutes.

L'heure la plus convenable peut varier selon les départements. En Angleterre durant la guerre, l'enseignement clinique se donnait régulièrement au London Hospital à raison d'une heure par jour, tous les matins.

L'institutrice tiendra compte des leçons données, du département, et si les leçons ont été omises pour quelle raison. L'élève tiendra aussi compte des leçons reçues.

La détermination et la persévérance ne sont pas moins nécessaires que la préparation et l'expérience de l'institutrice et de la préparation du programme — détermination et persévérance pour surmonter les obstacles, pour vaincre la routine, pour démontrer la nécessité de cet enseignement, pour obtenir le temps, l'espace et les élèves.

Je crois que l'effort en vaut la peine et que, par ce moyen, nous développeront encore davantage chez l'infirmière, l'intérêt envers le malade.

Références

1. Un Supplément au Programme d'Etude à l'Usage des Ecoles des Gardes-Malades du Canada.

2. Ward Teaching: Anna M. Taylor. J. B. Lippincott Co., Montréal.

3. *Notes de cours:* M. Lindeburgh, Université McGill. Soeur St-Louis, Institut Marguerite d'Youville.

Swelling of the Arm

By far the most important factors in the production of swelling of the arm following radical mastectomy are infection and x-ray dermatitis. Primary skin grafting has no influence on the occurrence of swelling. Furthermore, this swelling cannot be assumed to signify a recurrence of the carcinoma. The presence or absence of metastasis to axillary nodes at the time of operation has no bearing on the condition.

After swelling of the arm has developed the treatment is unsatisfactory. Conservative measures such as suspending the arm at night, gentle massage, and rest are rarely of lasting benefit. Some patients state that use of the arm increased the swelling, but a few stated that the swelling diminished after use.

The best treatment for this swelling is prevention. Every effort should be made to secure primary wound healing and to prevent the collection of serum under the flaps. All possible precautions should be taken to avoid roentgen-ray dermatitis by discontinuing therapy before ulceration appears. Extreme care should be taken to avoid even minor wounds and infections of the hands. When present these should receive prompt attention. It is important to warn these patients that the appearance of swelling does not mean a recurrence of their original disease.—*Surgery*

Nursing Profiles

Lillian Ethel Pettigrew, who for several years has been health instructor at the Winnipeg General Hospital, has been appointed executive secretary and registrar of the Manitoba Association of Registered Nurses. Miss Pettigrew brings to her new work a very broad and comprehensive understanding of present-day nursing problems. Graduating from the Winnipeg General Hospital in 1931, after a few months in private duty she was named as assistant to the executive secretary of the Canadian Nurses' Association and for seven years was in a key position to become familiar with nursing affairs throughout Canada.

The recipient of a scholarship from the Quebec provincial nurses' association in 1938, Miss Pettigrew qualified in public health nursing at the McGill School for Graduate Nurses and joined the staff of the Victorian Order of Nurses in Toronto. During her residence in Ontario, Miss Pettigrew took an active part in nursing association activity and was convener of the Public Health Section, District 5, R.N.A.O. She served as president of the M.A.R.N. for two years subsequent to her return to Manitoba in 1943. At the 1946 convention of the C.N.A., she was elected honorary treasurer. We all wish Miss Pettigrew great success in her new undertaking.

Davidson Studio, Winnipeg

LILLIAN PETTIGREW

Jenny McMartin Weir, B.Sc., M.A., has taken up her duties as lecturer in public health nursing at the Queen's University School of Nursing. Miss Weir graduated in 1941 from the University of Alberta Hospital. Following the completion of her university work, she joined the staff of the Metropolitan Health Committee, Vancouver, where she served until her enlistment as a nursing sister with the Royal Canadian Air Force in 1944. Miss Weir has recently completed the work for her Master's Degree in supervision in public health nursing at Teachers College, Columbia University.

Perhaps it was her experiences in the services which gave her the desire to learn to fly. Miss Weir hopes to secure her pilot's licence eventually. She is a skilled pianist, loves reading, dancing, and swimming. Our good wishes go with her as she commences her new activity.

Florence H. Martyn, B.Sc., who graduated from the Royal Alexandra Hospital, Edmonton, in 1915, has taken over the duties of superintendent of the nursing services in Bengal, India. Miss Martyn secured her certificate in midwifery in Ireland in 1917 and her degree from St. Joseph College, Hartford, Conn., in 1944.

Krass, Vancouver

JENNY WEIR

After over two years of missionary service in India under the auspices of the Church of England, Miss Martyn developed tuberculosis in 1920. During the "cure," she became especially interested in the work of medical laboratories. She has had extensive experience in this field in many parts of the world, her road finally leading her back to India. We wish her success and happiness in the expanding field of endeavor she has undertaken.

Ann Isobel Black, B.Sc., has been named assistant superintendent of the Victorian Order of Nurses for Canada. Six of the eleven years since she graduated from the University of Alberta Hospital, Miss Black has seen service with the V.O.N. in Winnipeg, Victoria, Hamilton, and Niagara Falls. For three years she was health instructor at the Winnipeg General Hospital and since 1944 has been in charge of the public health nursing course at the University of Manitoba School of Nursing. Miss Black has a thoughtful and progressive outlook on public health nursing and is well equipped to give leadership in her new work.

Olga Drover, a native of Newfoundland, who graduated from the Toronto General Hospital in 1943, has been appointed field nursing supervisor with the Newfoundland Tuberculosis Association. Following her graduation, Miss Drover spent some months in charge of the obstetrical department of Grace Hospital, St. John's. In the summer of 1944 she responded to the urgent appeal for nurses in England and took up active duty at the Emergency Casualty Hospital, Leatherhead, Surrey. This hospital was used as an evacuation centre for the wounded of London's flying bomb raids. Returning to her home in Newfoundland in late 1946, Miss Drover has been engaged with the Department of Public Health and Welfare.

Phyllis Wightman, whose varied nursing career since she graduated from St. Joseph's Hospital, Victoria, in 1924, has been full of interest and activity, has joined the staff of the Vancouver Children's Aid Society to be responsible for the health of the children who are wards of that organization. Miss Wightman joined the operating-room staff of her home hospital following graduation. For three years she was assistant matron of the Queen Alexandra Solarium, and for four years was supervisor and later acting matron at the King's Daughters Hospital, Duncan, B.C.

Imperial Studio, Hamilton

ISOBEL BLACK

Private duty experience has also contributed to her professional background for her new work. In her spare time Miss Wightman specializes in knitting and leathercraft.

Dorothy May Behrendt, a 1942 graduate of Royal Columbian Hospital, New Westminster, has been appointed superintendent of nurses of the Ladysmith (B.C.) General Hospital. Since her graduation, Miss Behrendt has been engaged in general staff nursing at the Nanaimo General Hospital; later she served in the surgery. Miss Behrendt is fond of reading and dancing though she draws the line at modern jive. Horseback riding is her favorite outdoor pursuit.

Alice Ethel Bingeman, a native of Bloomingdale, Ont., who graduated from Roosevelt Hospital, New York, in 1917, and who has been lady superintendent of the Freeport Sanatorium, Kitchener, Ont., for the past twenty-four years, has retired. Presentations

ALICE BINGEMAN

LYNETTE GUNN

were made to Miss Bingeman at the reception held in her honor, together with tribute to her unswerving loyalty and devotion to duty. Ill health occasioned by staff shortages during the war years forced Miss Bingeman's retirement before she had reached her cherished goal of a quarter of a century of service to the San. The *Journal* joins her many friends in wishing Miss Bingeman a speedy return to health and many years of happiness.

Lynette Gunn has resigned after seventeen years' service with the Victorian Order of Nurses in Winnipeg. Miss Gunn graduated from the Winnipeg General Hospital in 1920 and after a brief period of private duty in Manitoba and California went to New York and engaged in social service work. Upon her return to Winnipeg she joined the staff of the V.O.N., later becoming a supervisor, then assistant superintendent. Ten years ago she took the post-graduate course in public health nursing at the McGill School for Graduate Nurses.

Miss Gunn has been president of the W.G.H. alumnae association for the past two years. She is a member of the Business and Professional Women's Club. She is immensely proud of the certificate which she received from the Dominion Government for devotion to duty on the home front during the war years. Though she has retired, Miss Gunn intends to be active. "People," she has said, "no matter who they are or where they come from, are always interesting." With this as her motto Miss Gunn will find rich happiness in the years that lie ahead.

Canadian Nurses' War Memorial

(*Continued from page 828*)

all of them. If you wish to go farther afield, the public and reference libraries are also at your service. Do we not rather take it for granted now, that books will be available? How would we feel if these professional books were not on the shelves ready for us just to reach up and take the ones we need? Have we stopped to think that there are many, many nurses in Europe who have no nursing textbooks and no proper schools or classrooms in which to teach the young student nurses whom their countries so urgently need?

At the biennial convention of the Canadian Nurses' Association in Toronto in July, 1946, it was decided that the Canadian Nurses' War Memorial would take the form of the establishment of a nursing library or libraries in one or more of the countries whose libraries were destroyed by enemy action during the war. Personally I think of our Canadian Nurses' War Memorial as a tribute to *all* nurses for the work done during the war, when the many added demands were carried out so willingly by nurses in every branch of nursing throughout the world.

Some of you may not think it necessary to create a memorial. Whether in accord with the Canadian Nurses' Association on this subject or not, we must surely all agree that the world does need positive human relations of mutual aid and especially of assistance to the distressed and ravaged countries. There has been a vast uprooting of humanity, so widespread that we here in Canada, in one of the most favored parts of the world, have little realization of its extent. In what better way could we, the nurses of Canada, give assistance to European nurses who have shown such courage and fortitude, than by supplying them with professional books to enable them to rebuild their nursing libraries and their nursing profession?

Sure there is need of social intercourse,
Benevolence and peace and mutual aid
Between the nations in a world.

—AGNES C. NEILL in
R.N.A.O. News Bulletin

Notes from National Office

Executive Committee Meeting

A meeting of the Executive Committee of the Canadian Nurses' Association will be held at the University of Alberta, Calgary, December 5-6, 1947. On the two days immediately prior to this meeting a registrars' conference will be held at the School for Nursing Aides on the University of Alberta Campus, Calgary. This is the second such conference of the provincial executive secretaries and it is felt that this sharing of experiences is a most valuable factor in co-ordinating the various nursing activities across Canada.

The 1948 Convention

A special invitation is extended to schools of nursing all across Canada to plan to have at least one member of their student body attend the 1948 biennial convention of the Canadian Nurses' Association in Sackville, N.B., next summer. There is no more positive way to develop a healthy interest in association activities among the student nurses of Canada than by encouraging them to familiarize themselves with the full program of nursing through attendance at these conventions. It is suggested that the most effective means of stirring up this interest is where the student body raise the necessary money themselves to send their representative. Start planning now to have one member from your school present. If a sufficient number of schools are represented, it should be possible to incorporate some special features in the program to interest the student nurses especially. Let us know what you are planning.

Nurses' Interests

At a meeting of the Executive Committee, C.N.A., held on April 30, 1947, the chairman of the Program Committee for the 1948 biennial meeting informed the members of the executive that a large number of replies has been received to the questionnaire sent to nurses, through the provincial nurses' associations, for the purpose of determining their interest in establishing travelling institutes or refresher courses, and also to determine the subject for such course. It was felt that the workshop discussion plans for the next biennial meeting might assist in determining the nature of the course to be given and that implementation of this program might, therefore, be delayed until after that time.

The following motion was unanimously carried by the Executive Committee:

That the carrying out of the program of travelling institutes be delayed until after the 1948 general meeting.

British Nurses Relief

A letter received recently from the general secretary of the Royal College of Nursing, conveying the deep gratitude felt by all the members for the help and encouragement they have received from their colleagues in Canada, reads as follows:

You will remember I told you of the ideas the Council of the Royal College of Nursing had for utilizing the residue of the Civilian Nurses Air Raid Victims Funds. How they planned to allocate £5,000 to the Rest-Breaks service, leaving a certain amount to help those nurses, who, being permanently incapacitated, would still require

some assistance in addition to their State allowance. This has been done, and I am sure you will be glad to know that we have been able to purchase annuities for four nurses permanently disabled so that they will be relieved of financial worries for the rest of their lives. Others, unable to continue active nursing, have been retrained as social service workers, occupational therapists, almoners or teachers, and have benefitted immensely through the generosity of our colleagues in the Dominions.

As to the Rest-Breaks Houses, Her Royal Highness, Princess Alice, when officially opening Barton House Hotel on April 30, 1947, alluded particularly to the help that had come from the nurses of Canada for this project and in commemoration she planted a maple tree specially flown from Canada for this purpose. Contrary to all horticultural advice (for the tree was planted in the spring instead of the fall) it has taken good root and is flourishing. So there is a real living piece of Canada in the gardens of Barton House — a token of the friendship which exists between our two countries. We trust that as it flourishes and grows into a big tree, it may symbolize the growth of unity and friendship between us.

The main object of this letter, however, is to try to express our thanks to our Canadian colleagues for all that they have done and are doing to help us. For months past gifts of all kinds — food, soap, quilts, rugs, blankets, etc., have flowed into Great Britain and in addition yards and yards of very beautiful chintz and other material to provide curtains (or drapes, as you call them) for the Rest-Breaks House and annex. The rooms thus furnished, one being the dining-room, are perfectly delightful and all the visitors tell me how much they enjoy the color scheme and what a change it is from the prevailing austerity which we have to put up with in our homes.

It is impossible for me to tell you in so many words just what all this means to us but I hope that if any members of the Canadian Nurses' Association are in England they will visit Rest-Breaks House to see for themselves and will have a look at the special book which is kept there for recording gifts to the House.

It may interest you to have an extract from a recent letter from the Warden at Barton House about the guests who stay there. She says:

"The majority of our guests at present are middle-aged, and a good many are over sixty but there is a sprinkling of young student nurses. About one in twenty are matrons and others a mixture of sisters, staff nurses, midwives, district nurses, health visitors, and private nurses. Roughly about half are living in hospitals.

"They come chiefly for 'Rest-Breaks' and 'Post convalescence' as apart from holiday rests, and quite a fair proportion are recovering from serious operations.

"We find they arrive looking tired and often feeling the effect of climbing stairs for the first few days. After that, they seem to improve and brighten up to a remarkable degree. They are unanimous in their approval of Barton House, and the benefit they derive from their rest, also the wonderful air of Barton-on-Sea."

A constant and very welcome stream of food parcels have also been arriving at the College and it is our happy duty to distribute these to the nurses whom we feel are most in need of them. For one reason or another, probably the aftermath of war and over-exertion, everyone seems to complain of a great feeling of fatigue and many matrons tell me how often their student nurses complain of being tired. You will see, therefore, how helpful it is (a) to have a Rest-Breaks House to send them to and (b) to have these wonderful food parcels containing so many nourishing and stimulating articles. When distributing, we allocate them to four main categories: (1) elderly nurses; (2) nurses living alone and doing health visiting, domiciliary, or industrial nursing (these find it very difficult to manage on their rations); (3) those ill in hospitals or infirmaries; and (4) such places as the College Rest Home at Bonchurch, Isle of Wight, and Rest-Breaks House at Barton, where such an addition to the larder is a perfect godsend. By every post I am sure some Canadian nurse must be receiving a happy letter from the recipient of one of these parcels and here are a few remarks from letters which I have selected at random:

"Thank you for the lovely parcel which arrived safely this morning. I will certainly gain a few pounds in weight after enjoying its contents. Our colleagues in the Dominions have certainly been very generous providing us with such grand parcels. It is good to know that we have such kind friends in other countries, ready to lend

a helping hand in these hard times."

"This is the first parcel of any kind I have ever received, from overseas or anywhere, to help relieve my distress and I am most grateful to you and the giver who will soon receive my letter of thankfulness."

"The parcel came at a very nice time. I have an elderly nurse staying with me while she is changing her posts and when we opened it, well, our eyes danced! We had the sardines with bread and butter for our first course for dinner, then the tin of damsons with part of a milk pudding from the day before for our sweet, and then a nice cup of special tea and a slice of cake. Not even the Queen could have enjoyed her dinner more. It is not just the money value but they are things which make just the break from the daily round, so while we ate our meal we laughed and chatted and wished the dear nurses who had sacrificed things to give us this pleasure could have seen us."

"The parcel contains twenty-one tins or packets, practically all of which would be goods on points, or rationed over here. Apart from the impossibility of ever being able to queue for any little extras, many of these dainties would be quite impossible to find over here. I am writing at once to express my appreciation. As I am one of those who must take a packed lunch every day, I am more than ever grateful for this particularly generous and skilfully thought out gift. With very many thanks."

"I have just been ill and am only just beginning to feel myself again. Thank you very much indeed for the wonderful parcel which I received at the week-end. It was such a thrill unpacking it all and seeing what a variety of things there were. It was lovely and much appreciated."

"Many thanks for the gift parcel from Canada with such enjoyable contents. It does cheer one up to be remembered so kindly by you and friends abroad. God will reward and bless all such."

You will gather what a very real difference not only the kind gifts but the warm thoughts from Canada have made in the lives of British nurses.

And now for the future. Having got Barton House into running order, we are looking around for a similar property in the north of England, so that nurses from Scotland and the north can have a Rest Home without having a long and unpleasant journey to get there. This may take some little while especially as we shall have to get together something in the region of £30,000. We have a small nucleus of money already towards this and I expect before long to be able to report good progress to you.

Greek Nurses

"We wish to acknowledge having received from you a further donation of used shoes for the State School for Nurses in Athens, Greece. In this connection, we wish to quote from a letter which we have received from the Greek Red Cross:

"Will you please convey to the Canadian Nurses' Association our thanks for their kind gift, and let them know that we accept with pleasure hoping that, although used, these shoes will be useful to their colleagues in Athens."

Notes du Secrétariat de l'A.I.C.

Le Comité Exécutif de l'A.I.C.

Le comité exécutif de l'Association des Infirmières du Canada se réunira à l'Université de l'Alberta, Calgary, le 5-6 décembre 1947. Deux jours avant cette assemblée les registraires se réuniront en conférence à "School for Nursing Aides" (l'Ecole des Aides) située sur les terrains de l'Université de l'Alberta, Calgary. C'est la seconde fois que les secrétaires provinciales se réunissent en conférence, et l'on croit qu'en partageant dans ces réunions les expériences des unes et des autres, l'on a trouvé là un excellent moyen de co-ordonner les diverses activités du nursing au Canada.

Le Congrès de 1948

Une invitation spéciale est adressée à toutes

les écoles d'infirmières du Canada de se préparer à envoyer l'été prochain au moins une de leurs élèves au congrès biennal de l'A.I.C. en 1948 à Sackville, N.B.

Il n'y a pas de moyen plus efficace pour développer chez les élèves infirmières du Canada un intérêt vivace dans le travail accompli par les associations, qu'en les familiarisant avec toutes les questions du nursing par l'assistance aux congrès.

Il est suggéré, comme un excellent moyen de créer de l'intérêt, que les élèves trouvent elles-mêmes l'argent nécessaire pour envoyer leur représentante. Préparez-vous dès maintenant à avoir une représentante de votre école au congrès. Si un nombre suffisant d'écoles ont une représentante des choses intéressant tout particulièrement les élèves infirmières seront mises au programme. Faites-nous connaître vos plans.

Aide aux Infirmières de Grande-Bretagne

Une lettre reçue dernièrement de la secrétaire du Collège Royal des Infirmières transmet un message de reconnaissance de tous les membres qui ont reçu de leurs consoeurs du Canada, de l'aide et de l'encouragement:

"Vous vous rappelez que le Conseil du Collège Royal des Infirmières avait eu l'idée d'employer £5,000 (partie du résidu de la souscription faite pour venir en aide aux infirmières civiles victimes des bombardements) à des maisons de repos pour infirmière, ce qui laissait une certaine somme permettant d'aider les infirmières souffrant d'incapacité permanente, qui n'avaient que la pension que leur verse l'Etat. Celà a été fait et vous serez heureuses d'apprendre qu'il a été possible d'acheter des rentes viagères pour ces infirmières qui n'auront plus d'inquiétudes d'ici à la fin de leurs jours.

"D'autres, dont les infirmités ne leur permettaient plus de continuer à soigner les malades, ont été préparées à remplir des emplois en occupation theurapeutique comme travailleuses-sociales, économes, institutrices — toutes ces personnes ont bénéficié grandement de l'aide apportée par les infirmières des Dominions.

"Dans les maisons de repos, lors de l'ouverture officielle de l'une d'elles, Barton House Hotel, en avril dernier, la Princesse Alice mentionna tout particulièrement l'aide apportée par les infirmières du Canada et en souvenir de cet entr'aide planta un érable qui avait été transporté par avion du Canada pour cette occasion. Contrairement aux prévisions des horticulteurs (l'arbre a été planté au printemps plutôt qu'à l'automne) l'érable a pris racine et pousse bien."

La lettre se continue, exprimant toujours une grande reconnaissance et le bien que notre aide fait à ces infirmières qui joyeusement ont supporté les privations durant toute la guerre, espérant qu'avec la paix un peu de l'abondance du passé leur reviendrait et qui se voient encore privées, plus que durant la guerre, de nourriture de vêtements, de transport de charbon, etc.

Nos envois sont un rayon de soleil dans leur vie triste et un réconfort physique et moral. Les directrices des hôpitaux rapportent que les élèves se fatiguent facilement, qu'elles sont plus sujettes aux maladies. Les maisons de repos, où elles peuvent faire de courts séjours, leur permettent de refaire leurs forces. Le message se continue: "Les colis de vivres, adressés au Collège Royal des Infirmières, sont distribués comme suit: (1) Aux infirmières agées; (2) aux infirmières visiteuses vivant seules (il est très difficile de se débrouiller avec une seule ration); (3) aux infirmières dans les hôpitaux et dans les infirmeries; (4) et aux maisons de repos où tout surplus à leur ration est considéré comme un bienfait du ciel."

Des extraits de lettres reçues d'infirmières, remerciant pour des colis, montrent la joie, la reconnaissance et l'utilité de ces dons. J'en prends une au hasard: "Votre colis arrive au bon moment. J'ai une infirmière agée qui demeure avec moi pour quelque temps. En ouvrant votre boîte, nos yeux ont brillé de joie. Au dîner nous avons mangé des sardines avec du pain et du beurre, puis pour dessert nous avons ouvert la boîte de prunes. Nous avons fini notre repas par une tranche de gâteau et en buvant une bonne tasse de thé.

"Nous aurions voulu que l'infirmière qui a envoyé ce colis nous voit durant notre repas, nous avons causé, ri, comme si une fête avait interrompu notre routine journalière. Ces colis ont plus qu'une valeur matérielle—vos sacrifices nous donnent du bonheur."

Des Faits Intéressant les Infirmières

Lors d'une assemblée du comité exécutif de l'A.I.C., tenu le 30 avril 1947, la convocatrice du comité du programme pour le congrès de 1948 informa les membres du comité que l'on avait reçu un grand nombre de réponses au questionnaire envoyé aux infirmières par les associations provinciales, afin de savoir si

elles seraient intéressées à suivre des cours post-scolaires et à assister à des conférences et aussi afin de déterminer sur quel sujet devraient porté ces cours.

L'on pensa que les discussions, lors des réunions des divers cercles d'étude au congrès biennal, seraient de nature à déterminer les cours à donner et que par conséquent l'exécution de ce programme pourrait être retardé jusqu'après le congrès.

Le résolution suivante fut adoptée à l'unanimité par le comité exécutif:

"Que l'exécution du programme des cours donnés par une institutrice ambulante soient retardés jusqu'après le congrès de 1948."

Les Infirmières de Grèce

Les infirmières de Grèce remercient pour les chaussures reçues et demandent que les envois de chaussures usagées soient continués.

A Model Nurses' Home

Margaret Lawrence

Australia's newest and most up-to-date hospital, the Royal Melbourne, houses its four hundred nurses in a streamlined ten-storey building which provides all the conveniences of a modern hotel and all the comforts of a private home. Realizing the important part that living conditions play in promoting efficient service, the architects took special pains to provide comfortable and attractive quarters for the nursing staff. Completed in 1942 and known as the Charles Connibere Memorial Nurses' Home, it stands apart within the hospital grounds.

Student nurses accepted for the three-year general course at the Royal Melbourne Hospital begin their careers in ideal conditions. Girls fresh from school — many of them from the country and rather timorous about embarking on a career — are reassured by the friendly atmosphere. They find that the person in charge of the nurses' home is kindly and warm-hearted and they quickly learn to take all their problems to her. Also they are able to "find their feet" and make friendships among themselves before they need mix much with the more advanced student nurses and graduates.

As they settle down they begin to take more part in the activities of the Student Nurses' Representative Council, the elected body which looks after their interests in the management of the nurses' home.

Some of the senior graduates who have worked in many hospitals in several countries were recently discussing the remarkable absence of bickering among the staff, which is usually considered inevitable when large numbers of women are living together. They decided it was due partly to the size of the building, which allowed all the girls to get away by themselves when they felt

Comm. of Aus. Photo

Each nurse has her own bedroom

Comm. of Aus. Photo

Equipped kitchenette

inclined, and partly to the architects' forethought in planning.

At the Royal Melbourne, there is never any occasion for the sort of tension that develops when someone else has taken the only copy of the daily paper or got in first with the only comfortable chair in the common room or the only drying line for the washing. Every opportunity for a full and enjoyable social life is provided by the many pleasant sitting-rooms. Concerts and formal entertainments are held in the restful and spacious lounge on the ground floor.

Comm. of Aus. Photo

Hairdressing salon

Easy chairs, abundant flowers, attractive pictures by modern Australian artists, wide window-space, including the length of one whole wall, combine to create an atmosphere of comfort and charm. In addition there are cosy smoke-sitting-rooms on each floor.

The nurses share the dining-room in the main hospital building with the rest of the resident staff, but the kitchenettes adjacent to the smoke-sitting-rooms are very popular for casual snack meals and suppers. Each kitchenette is equipped with a refrigerator and electric kettle, griller and toaster, and there is plenty of cupboard space for the girls' own dishes. A practical device is a rubbish chute near the kitchenette which removes rubbish from all floors to a furnace in the basement.

On the ground floor are the music room and the reading and writing-room, where copies of the daily papers are provided. The nucleus of the growing library was purchased with funds raised by a concert given by the student nurses some years ago.

In too many hospitals, nurses complain that they have nowhere to entertain their friends. At the Royal Melbourne there are five visitors'cubicles, attractively furnished in a brown and fawn color scheme, where they can serve their guests with refreshments.

Just about the most popular room in the nurses' home is the milk bar, which is packed at all hours of the day with girls wanting a quick snack. Here, in dressing-gowns, slacks or housecoats, they can nibble a slice of toast while reading the paper, or enjoy a morning snack of ice cream, sandwiches, fruit or milk drinks, or whatever they fancy. Cost price only is charged.

As the new Royal Melbourne Hospital was completed at a time when building was restricted to absolute essentials, no provision for games was made. But future building plans for the hospital include three tennis courts, squash courts, and a recreation hall-gymnasium. As it is, the

Commonwealth of Australia Photo

Milk Bar in Nurses' Home

nurses are not far from tennis courts and other sports grounds.

The sleeping quarters show the same thoughtful consideration for the nurses' comfort as the social rooms. Each girl has her own bedroom, uniformly furnished in oak, and takes a pride in expressing her own individual tastes by the addition of her favorite flowers, photographs, and decorations. There are about forty bedrooms on each floor, and one bathroom to each four nurses.

Staff on night duty occupy two floors. Graduate and student nurses in different years of their courses also occupy separate floors, so that girls have the advantage of bedrooms near those of their own friends.

Laundering of uniforms is done by the hospital, but on each floor there is a laundry, complete with tubs, hot water service, electric irons and drying cupboards, in which the nurses can do their personal washing.

Examples of the practical way in which the nurses' leisure hours are provided for by the hospital planners are the sewing room, equipped with a power machine and a dressmaker's dummy; the hair-dressing salon, run by a private firm, and the hair-dressing room, equipped with electric dryers.

Another feature is the music room, in which nurses can indulge their fancy for boogie-woogie at the piano without disturbing those who are listening to a broadcast of a symphony concert in the lounge.

The nurses' home has its own office, which is open until 11 p.m. Here nurses can collect mail from their own letter boxes, post letters, send telegrams, buy stamps, have parcels left, make telephone calls, and so on. The switchboard transfers calls to telephone extensions on each floor.

Not all nurses find their living conditions as congenial as those at the Royal Melbourne Hospital; but as new hospitals are built and old ones remodelled, nursing quarters designed on modern lines will provide happy home surroundings for all nurses.

Vitamin Lack Affects Eyes

If your eyes tire easily, are watery and uncomfortable, and you suffer from headaches, the trouble may be that you are not eating enough riboflavin, or vitamin B_2. Investigations show that persons receiving an insufficient supply of this vitamin show changes in the small blood-vessels at the surface of the eyes, and the remedy is to eat more of such meats as liver and kidney, as well as of cheese, eggs, wheat germ, beans and peas. Milk also is rich in vitamin B_2.

—*Health News*

Food Poisoning

M. Mitman, M.D., F.R.C.P., D.P.H.

It is popularly believed that food which does not smell or taste spoiled is safe for eating. This is a fallacy: dangerously contaminated food may appear quite wholesome. The case is reported of a Belgian sanitary inspector who was asked to examine some sausage thought to have caused illness among workmen. He was so satisfied with the excellent appearance, good color, and smell of the sausage that he pronounced it good and ate some to prove its harmlessness: he was dead of food poisoning within a week! On the other hand, food undergoing putrefaction may be unpleasant to the smell and taste but does not necessarily, or even ordinarily, produce substances capable of causing human food poisoning. Limburger cheese and high game are both undergoing putrefaction but are not poisonous. It is worth mentioning that the term "ptomaine poisoning" has been abandoned. The word "ptomaine" comes from a Greek word meaning "corpse" and was used to denote toxic substances arising in putrefying food. Chemically the word is meaningless, and is never used by those with knowledge of food poisoning.

How Food Poisoning can be Caused

It was once widely believed that tin, aluminum, copper, and nickel in utensils or cans were capable of causing poisoning. In fact, however, in the form in which they appear in the kitchen they are not dangerous, and chemical food poisoning is rare. There have been examples of antimony in cheap grey enamel causing trouble and of cadmium in plated metal containers getting into acid foods prepared in them, but as soon as manufacturers had their attention drawn to these things they were eliminated. Certain metal polishes and cleansers containing cyanide are, however, poisonous and must not be used in the kitchen. Instances have occurred of harmful chemicals getting into food in mistake for other substances. Sodium fluoride, a poisonous chemical sometimes kept in the kitchen and used for killing cockroaches, resembles baking soda so closely in appearance that it has been used in error with serious results.

Everyone is familiar with the danger of consuming poisonous fungi in mistake for edible mushrooms; but it is not so widely known that rhubarb leaves which contain a poisonous chemical, oxalic acid, were used in the first world war as substitute for spinach!

Shell-fish may cause trouble in a number of ways. Outbreaks of mussel poisoning have been reported due to poisonous food (plankton) consumed by the mussels themselves; but most shell-fish poisoning is due to one of two other causes: either it is due to hypersensitivity of the consumer to perfectly clean, wholesome fish, and is not poisoning in the strict sense at all, but is rather an "allergy," or is due to organisms which reach the shell-fish beds from sewers.

Much the commonest causes of food infection and poisoning, however, are germs and their poisonous products—the toxins. The illness they cause usually takes the form of gastro-enteritis, with symptoms of diarrhea, vomiting, and cramping pain in the abdomen. Depending on the particular germ present, the illness may take other specific forms such as paratyphoid fever, dysentery, scarlet fever, septic sore throat, or botulism; trench mouth and infantile paralysis may also be conveyed by food. Even influenza, the common cold, and tuberculosis have been attributed to infected food or crockery, but if infection by such means occurs it is unusual, for they are usually contracted from breathing heavily infected air.

To grow germs in a laboratory it is necessary to put them into a

culture medium containing suitable food and to keep them at a warm temperature. Meat broth, milk and eggs are good substances to use as media. Under favorable conditions, the organisms multiply every half-hour, so that in 12 hours a single germ may produce 15½ millions and half-an-hour later 33 millions. If, however, the temperature is too cold, the germs stop multiplying, although they do not necessarily die.

It is thus possible to state the conditions necessary for an outbreak of bacterial food poisoning. First, the food must be contaminated with the germ. Second, the food must be of a type which will allow the germs to grow. Third, the food must be incubated (i.e., kept suitably warm) so as to promote growth of the germs.

To deal with the last two points first: It has already been mentioned that prepared meats, milk, and eggs are suitable media for bacterial growth; and their products such as sausage meat, croquettes, pies, pastries filled with artificial or real cream, custard-filled bakery products and ice cream are most often responsible for food poisoning. Two examples will demonstrate the part incubation plays in food poisoning. A woman, living alone, opened a tin of good soup and inadvertently a little pus from a wound on her thumb got into the soup. She consumed half the tin without ill effect and left the remainder in her warm kitchen for seven days. She then warmed it up and consumed it. Within three hours she was violently ill with diarrhea and vomiting, and within twenty-four hours she was dead. A week's incubation had made the soup lethal. In another case, some ice cream mixture was allowed to stand for twelve to twenty hours before being frozen. When consumed later it caused food poisoning, whereas some similar material not left standing about caused no trouble.

Mode of Contamination

How is the food contaminated in the first place? Usually the germs are deposited on it by human beings, by animals such as mice and rats, or by insects such as flies. It is rare for food to be contaminated before it reaches the caterer, because of the fairly rigid inspection of food (particularly meat) by the public health authorities. There was, however, a little relaxation during the war and examples of such infection occurred. Dried eggs sometimes contain salmonella germs, while pork products may be infected with the trichinosis parasite capable of causing illness. (It is advised that all pork products should be thoroughly cooked to destroy these organisms.) Recently there was an outbreak due to unwholesome rabbit. A large consignment of rabbits included one animal which was diseased before it was caught and which escaped detection during inspection. All the rabbits were cut up, and parts of the diseased carcass got into three pies while two dozen other pies were not contaminated. Those who ate of the tainted pies were affected (not seriously) while all the others escaped. In tracing the cause of this outbreak the difficulty was to determine why so few groups were affected although all had apparently eaten the same food.

Mice and rats sometimes suffer from an infection which is capable of causing poisoning in humans if their droppings or urine contaminate food. Flies also act as conveyors of infection, and such fatal diseases as infantile diarrhea, dysentery, and poliomyelitis have been attributed to such carriage. The germs causing food poisoning, however, are often derived directly from human excreta.

In the past, before excrement was dealt with in a sanitary manner, it was deposited on the ground thus contaminating wells and other water supplies and causing such diseases as typhoid fever. Today, the proper disposal of sewage and the provision of a pure water supply are guaranteed in most countries by the public health authorities. During the war, in Great Britain, there was the fear that damage to sewers and watermains by enemy action might result in contamination of the water and, to counteract this danger, antiseptic

substances were added to the water. The unsatisfactory water supply in some countries explains their inhabitants' preference for the safer bottled waters, but water-borne diseases are rare today.

Excreta may also be carried to food by the hands of those preparing it. If a kitchen worker is infected he may easily and unknowingly carry a few germs on his hands after using the sanitary convenience. He may have recently suffered from a diarrheal disorder or may be a carrier (i.e., a healthy person who carries the germs in his intestines without himself suffering any ill effects). If the germs he carries are passed on to others they may cause serious illness, and every kitchen worker affected with diarrhea should, therefore, report such illness to his doctor and employer. *The most important rule of personal hygiene for kitchen staff is to wash the hands with soap and water after using a sanitary convenience*, and it is advisable to post a notice in the lavatory instructing the staff to do so. The law now requires facilities to be provided in catering establishments for such washing, and hot water, soap and towels must be available. Indeed, it is sound hygiene for all to wash their hands before preparing or sitting down to a meal.

Food may also be contaminated by germs from the skin, the nose and throat. Septic sores and boils on the hands and arms contain bacteria capable of causing disease, as the above-mentioned case of the woman with the tin of soup illustrates. Staff suffering from such skin ailments must not, therefore, handle food until the condition has cleared up. The nose, particularly after a cold, is the home of many germs. It is surprising how frequently people's fingers stray to their noses, and germs capable of causing illness are also expelled during coughing and sneezing. The mouth and nose must, therefore, be guarded with a handkerchief at such times, special care being taken not to cough or sneeze over food or to touch one's nose while handling food.

Cleanliness of Premises, Equipment and Utensils

So much for personal hygiene; now let us discuss the cleanliness of the premises. General cleanliness of the floors, walls, ceilings, and doors is only possible if they are kept in proper repair. If food is properly stored and cleanliness observed the prospect of infestation by mice and rats is diminished. A warning should be given about the use of commercial rat and mouse poison; there is danger that the germ causing disease in the rodent may be conveyed to food and cause food poisoning. A kitchen worker who squeezed a mop out after using it on a floor laid with this bait infected her own hands and thus the food she was preparing.

Much greater care is also needed in the disposal of refuse and waste, because it will do much to eliminate the fly population. Garbage cans should be properly covered with water-tight lids, emptied regularly and frequently, and cleaned, preferably with a steam jet. Garbage collectors should avoid bruising cans by rough treatment and thus damaging the rims so that the lids no longer fit. There is a great advantage in grading refuse into plain refuse and ashes; waste food; bones and waste fats; and paper and tins. In the future, DDT will help us to destroy flies, but it will not eliminate the cause of their presence.

Lastly, something should be said about the cleansing of equipment and utensils. Crockery, particularly when dirty and cracked, has been found to harbor germs capable of causing disease. Soap and water liberally supplied is a highly efficient disinfectant, but how frequently is washing-up performed in a most perfunctory manner, particularly during rush periods? The washing water should be warm (110-120°F.), contain an adequate amount of soap, and changed as frequently as is necessary. After washing, rinsing in really hot water (170°F. for two minutes or boiling water for half a minute) will remove the cleansing material.

STUDENT NURSES PAGE

Bacterial Pericarditis

GERALDINE ALLBEE

Affiliating Student Nurse at Children's Memorial Hospital, Montreal, from Rutland, Vermont

ONLY THIRTY-SIX hours before admission to the hospital, Richard wakened during the night and complained of earache. He was unable to sleep and felt warm to touch. During the day the earache diminished, but he began to have slight difficulty in swallowing, and his voice became hoarse. Later he complained of abdominal pain, had considerable difficulty in swallowing, and vomited twice. He was seen by his doctor who advised admission to hospital.

At the time of admission the fever was 102°F. A tentative diagnosis of pneumonia was made, and treatment with penicillin started immediately. Physical examination showed, according to the interne's report, a child who was breathing with rapid, grunting respirations, with lungs which seemed normal to percussion and auscultation. The heart was not enlarged and there was no murmur. Examination of the abdomen showed marked rigidity and spasm which seemed to be generalized with some increased tenderness in the upper quadrants. Thus the possibility of appendicitis was introduced. The throat was red and the uvula swollen. The surgeon was called in consultation and he advised waiting and watching. During the night the doctors felt that the abdominal signs pointed to thoracic rather than abdominal disease, and a rapidly enlarging heart suggested acute pericarditis. Finally the heart specialist, with the aid of x-ray, E.C.G. and signs which developed rapidly in the child, was able to confirm the diagnosis of acute bacterial pericarditis with purulent effusion.

Bacterial pericarditis is not common in infancy and early childhood, but when it does occur at an early age it most frequently results from the extension of an infection in the respiratory tract. This commonly produces a suppurative type of pericarditis which causes a high mortality rate. There may be no local signs to focus attention on the pericardium.

As soon as diagnosis was definitely established, the medical treatment consisted of the following:

Aspiration of the pericardium daily; penicillin, 10,000 units every three hours; streptomycin, 50,000 units every three hours; intravenous therapy; oxygen tent for cyanosis.

During the time I nursed Richard there were three special problems that existed. He was irritable, he had little or no appetite, and he seemed unable to lie passively in bed while I was attending to his physical needs. It took patience to ignore the irritability and to do things slowly without feeling strained. He needed some diversion, but the physical condition dictated something simple which required no concentration, strain or excitement. He enjoyed

small dolls, picture books, listening to stories and, best of all, he liked a small plastic doll carriage. When I removed his toys for the night I was careful to place the carriage where he could reach it saying, "Richard, I will put it here where you can reach it when you wake up." He often "fussed" upon awakening, asking for his father and mother. He was interested in stories and I found reading to him the best way of putting him to sleep. He was too ill to hold attention for long and would drop off to sleep fairly soon. I would try to find something different every half-hour or so if he were awake.

The child's appetite was poor but the management of the food problem was not too difficult. I served his food in very small amounts, cutting his bread in small pieces, and he soon began to improve. He usually wakened at 9 p.m., and as he was fond of chocolate milk there was a drink ready for him. He needed a considerable amount of fluid to combat the infection, the fever, and the loss of fluid through perspiration. He was good about taking fluids.

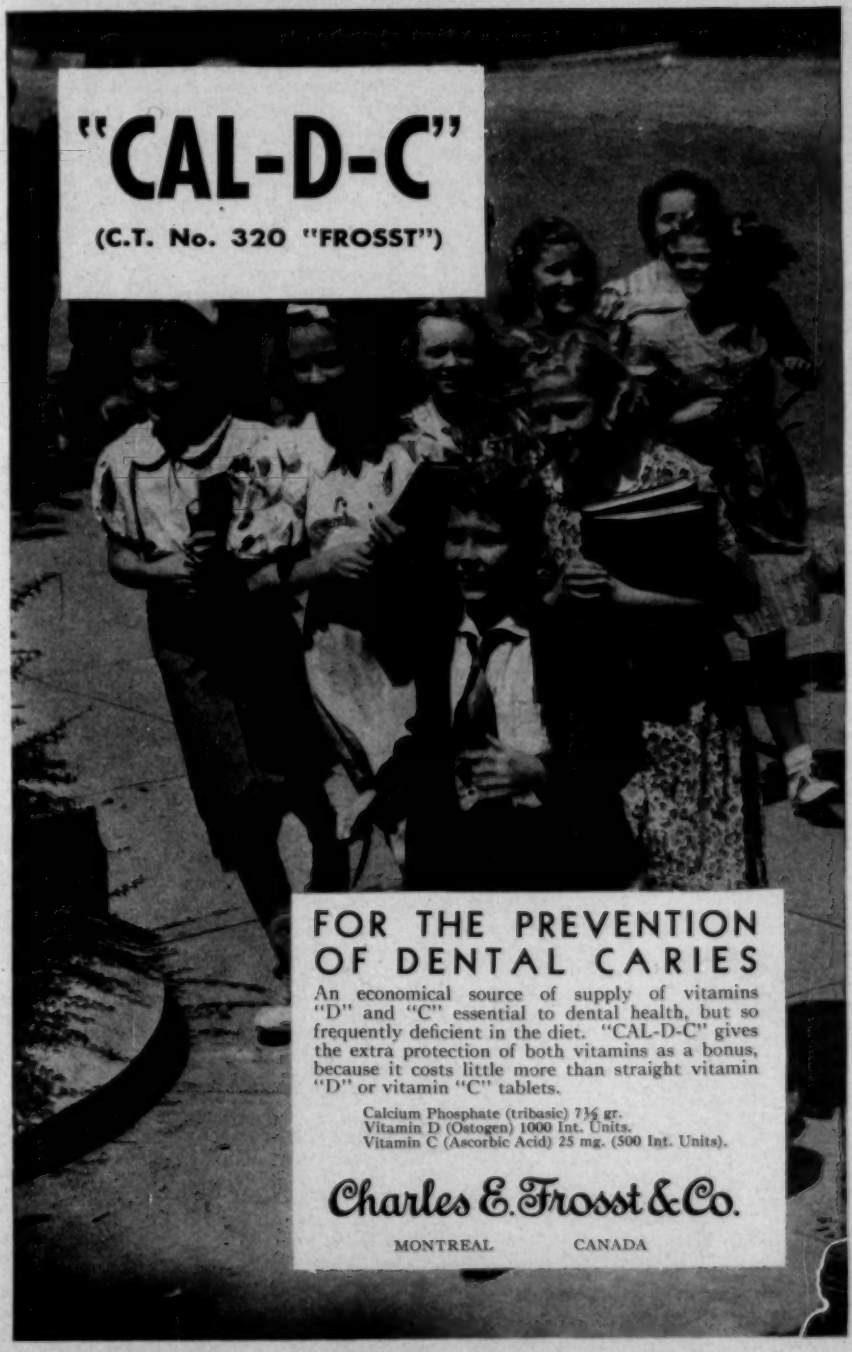
The general care which Richard required was similar to that of any acutely ill and febrile patient, except that it was difficult to save him physical exertion. He could not understand what I meant when I asked him to lie still and I would lift and turn him. Before I could move him he would have struggled by himself and he never did learn to lie passively in bed. Flannelette sheets were used because of the excessive perspiration and they required frequent changing. He was supported up in bed with pillows. He was tired after bathing so that sponge baths for fever were not given. The doctors depended upon chemotherapy and aspiration of the purulent material from the pericardium to control the infection. He was very co-operative during the intramuscular injections and the pericardial taps. In the first instance I was careful to explain to him and to tell him the truth. Eight days after admission chemotherapy was discontinued, and on the twelfth day the pericardium seemed to be free of purulent material. Richard had been healthy before this illness, he came from a good home, and his parents were capable of convalescent care under their doctor's direction. Consequently, he was discharged home sixteen days after admission, having made a remarkable recovery. He was an interesting patient and I learned that understanding the child and caring for him as an individual is an important part of pediatric nursing.

What is a Profession?

The following was presented by Professor R. Freeman Butts, Teachers College, Columbia University, as part of the panel discussion on "Employer-Faculty Responsibility in Developing Nursing Personnel on the Job and in the University," at the conference and reunion, Alumnae of the Nursing Education Division, Teachers College, Columbia University, May 20, 1947:

As a proposal for your thinking and discussion, I suggest that the following are seven characteristics that a group of people must have in order to reach full status as a profession. I suggest them as a check list by which to measure whether the nursing profession, the teaching profession, or any other profession may have the right to call itself a profession:

1. The group must be organized. No group of people is a profession unless it is organized in such a way as to enhance the consciousness of the worth and integrity of the group as a means of rendering a service in some aspect of the everyday life of the people. Thus, a profession has a basically collective character through which the individuals heighten their powers and facilities for rendering that service.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2. The group must rest its services upon the mastery of a common body of knowledge and skill. This mastery depends upon spending considerable time in supervised study, learning, and practice before the member is permitted full standing in the profession. The attainment of the requisite knowledge and skill is in large measure an intellectual task requiring university-level study. The mastery of scientific, philosophic, and theoretical knowledge is a requisite that characterizes one group a profession, the lack of which characterizes another group as a less well-developed occupation.

3. The group must have a large share in determining the qualifications which must be possessed by those who would enter upon the profession. Since an extended period of study is necessary as a preparation before and after entering the profession, the standards of admission must be worked out by the profession and by the public working co-operatively. A profession should not be given complete autonomy in this regard nor should a public or private agency be given full authority for determining such qualifications.

4. The group must develop a code of ethics governing the relations of its members to the public and to each other. This must be generous and devoted to the welfare of all concerned and not limited to what will merely help the practitioner.

5. The group must be officially recognized by the government of the people whom the profession serves. Whatever licensing or approval is necessary for practising the profession must be officially a matter of recognition by some agency that is responsible to the public.

6. The group must achieve an economic and social status that is sufficient to attract and hold persons with high intellectual and personal qualities. Nursing and teaching have a peculiarly difficult task in this respect, because, of all the professions, they most commonly rest upon salaries paid by an employer rather than upon fees paid by a client or patient. This makes the kind of professional organization that is developed for these groups of very great importance as a means of achieving the status and rewards worthy of a profession. The public will pay adequate salaries when it is convinced of the worth of the service. This "convincing" is difficult and often a political task.

7. The group must have effective working relationships with other groups in society. This means that a profession may and oftentimes must work not only with other professional groups but also with labor and other private and public organizations as a means of mobilizing efforts for shaping public policy with respect to the services it represents.

Above all, there must be a recognition of the general social welfare involved in the practice of a profession. The public and general welfare must take precedence over the individual and private interest. When any occupational group links its service functions with a liberal understanding and appreciation of the social and cultural context in which those services are rendered, that group moves in the direction of a profession.

A profession, in other words, has basically an educational function. One who "professes" is one who has something to teach to others. A profession has the educational function to lift the quality of life in a community. I sum up this function in the words, "education of the public." All professions must be engaged in the education of the public, not simply in providing the opportunity for the professional worker to earn a livelihood, or to make money, or to sell his services.

—*New Jersey State Nurses' Association Bulletin*

Co-operative Refresher Course

For the last few years, at every meeting of the Cornwall Chapter the question has been asked, "What shall we do to broaden our educational interests?" And the answer usually given was—"A modified refresher course, perhaps?" So, last spring, the nebulous refresher course evolved into reality.

With the rapid developments in all fields of medicine as a result of accelerated scientific research which goes hand-in-hand with each succeeding war—one indirect outcome of war that we can be thankful for—one finds it difficult to keep abreast of these many achievements. We are so busy nursing that

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there is little time for study; yet, without continued study we cannot be good nurses! So, in an effort to circumvent this vicious circle in our own little sphere, we got down to the serious business of planning a series of lectures and demonstrations.

The committee was composed of the local R.N.A.O. convener of Nurse Education, Sister Margaret Mary, Sister Mooney, and Miss Evelyn Paul, convener of Education for the Cornwall Nursing Registry.

Our first plans were somewhat elaborate; we thought of having lectures twice a week for a month. The idea was voiced at a registry meeting last November at which Miss Madalene Baker was present. Miss Baker kindly suggested that we "tone down" a little on our initial venture, that is, that we decrease both the number of lectures and the time spacing. We are grateful to Miss Baker for this suggestion as it subsequently proved more effective.

After much changing and arranging, and with the invaluable advice and assistance of Dr. Lorne A. Caldwell, who is on the Education Committee of the registry, the program was mailed to all nurses in the district, both graduate and student, as well as to some alumnae members working not too far distant—Montreal, Potsdam, Massena, etc. Embellished with appropriate sketches depicting the theme of various lectures, it read as follows:

YOU are cordially invited to attend the refresher course sponsored by the Cornwall Chapter of the R.N.A.O. and the Nursing Registry, to be held at the Cornwall General Hospital, Nurses Residence, with the following program:

First evening: Mr. William Mitchell: "First aid with particular reference to artificial respiration." Rev. Sr. Margaret Mary: "Wangensteen suction apparatus." Lecture and demonstration.

Second evening: Dr. A. E. R. MacPhee: "Anesthesia." Dr. L. A. Caldwell: "Some pertinent points of interest to nurses regarding fractures, from Sir Reginald Watson-Jones's lectures in Toronto, January, 1947."

Third evening: Miss Margaret McKenzie, Dept. of Public Health: "The nurse's responsibility in venereal diseases." Miss Sybil Everitt, Victorian Order of Nurses: "Delivery in the home." Lecture and demonstration.

Presentation of prizes by Dr. Roy McGregor Nichol for student nurses' posters. Poster topics as follows: Intermediate students: Intravenous Therapy; senior students: Progress of Nursing.

The posters, prepared and displayed by the student nurses of the two Cornwall hospitals, were exceptionally well done and showed a wealth of careful planning and painstaking execution. The senior students of the Cornwall General won the prize for their poster depicting the progress of nursing and the Hotel Dieu intermediate students won the prize for their poster on intravenous therapy. In presenting the prizes, Dr. Nichol congratulated the student nurses on their artistic work.

Some sixty nurses registered for this course and everyone was most enthusiastic, both about the educational achievement and the pleasure of the social aspect of the event. The net proceeds, on the basis of three dollar registration fees, was seventy dollars. It has been banked to be used in arranging for the next refresher course. We hope to make it an annual event.

Industrial Nursing Refresher

Miss Caroline Barrett, chairman, English Chapter, District 11, A.N.P.Q., introduced the speakers at the first two lectures of the series arranged for nurses in industry by the Public Health Section, A.N.P.Q.

On May 14, Dr. Graham Ross, chief medical director, National Breweries, opened the series, speaking on "Industrial Nursing and Personnel Relationships." The object of the medical department in industry is to keep the whole working force in a state of health and efficiency, Dr. Ross told the group. Thus, preventive measures are an important part of industrial medicine. The nurse in industry has a very real opportunity for health teaching in her frequent contacts with the same people over a long period. She may be somewhat restricted in an industrial medical

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centre because "production" is the important thing in industry; she, too, must show a "profit."

Dr. Ross felt that the medical department was in a splendid position in industry, being between management and the employee, and should maintain this advantage, avoiding any inclination to "take sides," and thus keep the confidence of both.

Dr. Fred Smith, Dean of Medicine, McGill University, spoke on "Newer Drugs and Recent Developments in Therapy" at the second session on May 21.

Dr. Smith dealt only with the antibiotics—the sulphas, penicillin, and streptomycin.

It was interesting to learn that the group of diseases for which penicillin is effective are scarcely affected by treatment with streptomycin, and *vice versa*. Unfortunately, neither drug affects the many virus and fungus diseases. The lecture was much appreciated and thoroughly covered this topic of current interest.

Miss Elinor Barnstead, supervisor of Case Work, Family Welfare Association, spoke on the subject "Community Resources" on June 4. Miss Barnstead was introduced by Miss Electa MacLennan, assistant director, McGill School for Graduate Nurses.

Miss Barnstead outlined the many problems which might be on a worker's mind, and affect his health and his job. These would mainly come under two headings: *Home problems*, including illness of employee or a member of his family; behavior problems of children, particularly when both parents are working; domestic trouble between husband and wife; pregnancy; unmarried mothers; debts or poor management. *Social problems* would include: housing shortage; hospital bed shortage; dearth of domestic help; and lack of adequate day nurseries.

Miss Barnstead urged the nurses to use the services offered by the agencies. The nurse referring a case can be of immense help by properly preparing the patient, explaining that a welfare agency is more than a charitable institution.

The final lecture of the series was on June 11. Miss Mary Mathewson, superintendent of nurses at the Montreal General Hospital, was chairman and introduced the speaker, Miss Frances Harris, consultant on industrial nursing with the Department of National Health and Welfare.

Miss Harris summed up the previous lec-

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tures regarding the position of the nurse in industry. She pointed out some of the opportunities for helping the employee himself, his family, and the community in general. The nurse in industry, knowing the patient, his family and background, must act as interpreter, clarifying the situation for the doctor, since in the large and complicated social set-up of today the doctor cannot possibly know these things as the old-time general practitioner did.

There was some discussion afterwards of particular problems the nurses have met. The lectures were well attended and enthusiastically received, and the committee feel well satisfied with the venture.

Book Reviews

A History of Nursing, by Gladys Sellew, Ph.D., R.N. and C. J. Nuesse, Ph.D. 444 pages. Published by The C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1946. Illustrated. Price $4.00.

Reviewed by Aileen Riordan of Montreal.

This book is a valuable addition to the many references available for teachers and students on History of Nursing. It is a convenient size, attractively bound, well illustrated and is printed in a clear type on semi-gloss paper. The table of contents, because of the generous number of sub-headings for each of the twenty-one chapters, facilitates its use as a reference. Some additional teaching and learning aids are the "Questions for Study and Discussion," and the many references—historical, cultural, and social—listed under "Suggestions for Reading" at the end of each chapter.

In the preface the authors challenge nurses, in the light of a true understanding of their professional duties, to strive for an insight into contemporary problems, past and present, and to active participation in the solution of future ones. *In the book* they adhere to the central thesis—the inextricable interweaving of nursing service with all other branches of human culture. Historically

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interwoven through many chapters is the ennobling effect upon nursing of the Christian tradition which makes men see Christ in their neighbors.

To nurses in the United States this book should have a special appeal—six chapters being entirely devoted to subjects of particular interest to them; to Canadian nurses a more limited one in terms of the incompleteness of the contribution of History of Nursing for Canada. A striking example of such incompleteness is the listing on page 410 of the Canadian University Schools of Nursing. Despite this, however, the book is a useful reference.

Improvised Equipment, in the Home Care of the Sick, by Lyla M. Olson, R.N. 265 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 4th Ed. 1947. Illustrated. Price $1.75. *Reviewed by Cecilia Pope of Moncton, N.B.*

The author has successfully collected a large body of new and concretely applicable information and suggestions in this latest edition of "Improvised Equipment" for use in the home, or in the small hospital of limited means, as the outpost or cottage hospital. The topical grouping of subjects and the clear illustrations increase the value of this text for ready reference.

Although public health nurses in general are trained in and have experience in methods of improvising equipment in the home, the average private duty nurse tends to feel inadequate in such a situation, and often quite unequal to the occasion. Both the public health nurse doing bedside nursing, for her own additional information, and the private duty nurse, with perhaps little experience of home improvisations, should find this book most useful for their work in the community. The suggestion that Red Cross workers, practical nurses, mothers, camp directors, and others engaged in welfare work can apply this information, is worthy of consideration by those who are conducting their classes in home nursing. The student nurse would find this edition very helpful in the school library to supplement the usual rather meagre classroom instruction on home improvisation. This book ably stimulates the imagination, and the ingenious-minded nurse should readily progress by herself to additional forms of improvisation, while the less imaginative type should find satisfaction and more self-confidence in having such guidance available.

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Easy Crafts, by Ellsworth Jaeger. 129 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1947. Illustrated. Price $1.95.

When there is no occupational therapy department in a hospital, the nurses frequently find themselves at a loss when it comes to keeping convalescing youngsters out of mischief. Older patients, too, who find the time hanging heavily on their hands can become interested and intrigued by the simple crafts which are described in this little manual. Since a minimum of equipment is required for many of the fascinating crafts described, they could readily be introduced into almost any situation.

Each craft is graphically illustrated. The line drawings on one page and the directions on the opposite page make it very easy for any one to follow the instructions. Children and adults alike would enjoy "spatter printing," cutting "snowflakes," or the various Indian designs which are illustrated, to mention only a few of the sixty-four crafts.

Color Atlas of Hematology, by Roy R. Kracke, M.D. 204 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1947. 32 plates in color; 3 in black and white. Price $5.00.

Reviewed by Lillian E. Martin, Director of Laboratory, Calgary Associate Clinic, Alta.

Informative and concise is this Atlas of Hematology. The text, with its accompanying color plates (really resembling what we see under the microscope), is conveniently arranged. The reader will not be burdened with excessive detail or elaborate techniques, but will find a wealth of information in a nutshell.

For the general practitioner it will be of inestimable value as a reference. The laboratory technician should find it stimulating as a review and an incentive to study.

This book should prove interesting and enlightening to the graduate and student nurse. The chapter on definitions alone should make clear some of those "queer laboratory reports," consequently enabling her to give more intelligent assistance.

It is divided into twenty-three short divisions on origin, development and morphology of red and white cells. Common and rare diseases of the blood and blood-forming organs are discussed. A section devoted to hematologic techniques gives simple and accurate methods on many common tests.

Osler said, "Books are tools, doctors are craftsmen, and so truly as one can measure the development of any particular handicraft by the variety and complexity of its tools, so we have no better means of judging the intelligence of a profession than by its general collection of books." Dr. Kracke's Atlas of Hematology is a most useful tool.

A Ward Pocket-Book for the Nurse, by Hilda M. Gration, S.R.N., S.C.M., D.N. (Lond.). 107 pages. Published by Faber & Faber Ltd., 24 Russell Sq., London, W.C.1, England. 1st Ed. 1946. Price 3s. 6d.

Reviewed by Edith Green, Instructor, Royal Jubilee Hospital, Victoria, B.C.

The author of this handbook is sister tutor at Guy's Hospital and examiner in nursing for the General Nursing Council of England and Wales, but her material offers little to Canadian nurses.

It is a flimsy little pocket-sized volume "designed to . . . be carried in the pocket and used as a book of reference." Covering general nursing procedures, it attempts to list for each the equipment necessary, with no mention of purpose or method of procedure. Twenty introductory pages illustrate by sketches some common articles of equipment and brief tables add such data as weights and measures, food values and urinalysis.

The equipment notes could be of service as summary for an individual hospital, but have no universal application. The vocabulary is also a limitation. We do not commonly use gallipots, vomit cloths, or trolleys; nor is it usual practice to take along a pail of sand and a rug when a "spirit lamp" is used. It is hard to believe that any nurse needs to carry in her pocket *sketches* of clinical thermometers, rectal tubes, and suture needles.

Any information which might have value is available in more reliable form in ward manuals and many other reference sources. The book cannot be recommended for use outside its own locality.

Nursing Sisters' Association

The *Saskatoon Unit* sponsored the first fashion show of the season in the Hudson Bay Auditorium in aid of British nurses. Two attractive door prizes were given away.

Following the show tea was served. The

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guests were welcomed by Mrs. G. W. Parker, representing the sisters of World War I and V. Bergren those of World War II. Mrs. J. E. Porteous was in charge of the register. Presiding at the tea table were Mmes R. Pinder, A. C. Wensley, R. Savage, and A. W. McPherson. H. Bright was the general convener and H. Rath was in charge of the table. Assisting were Mmes J. Atkinson, W. H. Hicks, J. C. Lee, K. Hugal, R. Pinder, Misses S. O'Connor, E. Welsh, A. Meadows, M. Waterman, L. Friesen, E. Christie, L. Krotenko, H. Woods, and P. Parker.

Ontario

The following are recent staff changes in the Ontario Public Health Nursing Service:

Appointments: *Lenna Richardson* (Hamilton General Hospital and University of Western Ontario certificate course) as public health nurse, Dundas Board of Health; *Audrey Lamb* (Royal Victoria Hospital, Montreal, and University of Toronto certificate course), formerly with East York-Leaside health unit, to Kent County health unit; *Mrs. David (Fox) Currie* (Grace Hospital, Toronto, and University of Toronto certificate course,) New Toronto Board of Health; *Jean Johnston* (Guelph General Hospital and University of Toronto certificate course), Peel County health unit; *Sarah Cameron* (Montreal General Hospital and University of Toronto certificate course) and *Dorothy Sanderson* (Toronto General Hospital and University of Toronto certificate course), Halton County health unit; *Thora Gerow* (Belleville General Hospital and University of Toronto certificate course), United Counties health unit; *Patricia Robertson* (Woodstock General Hospital and University of Manitoba certificate course), Woodstock Board of Health; *Isabel Husher* (B.Sc., University of Western Ontario), London Secondary Schools nursing staff; *Jessie Smith* (Victoria General Hospital, Halifax, and University of Toronto certificate course), Kirkland-Larder Lake health unit; *Mrs. Madonna (Hurtubise) Richer* (St. Michael's Hospital, Toronto, and University of Toronto certificate course), Porcupine health unit; *Neta Moore* (Victoria Hospital, London, and University of Western Ontario certificate course) and *Frances Walton* (Woodstock General Hospital and University of Western Ontario certificate course), Oxford County health

unit; *Clara S. Kiltmer* (Woodstock General Hospital and University of Western Ontario certificate course), formerly public health nurse in Village of Ayr and Townships of North Dumfries and Wilmot, Newmarket Board of Health.

Resignations: *Mrs. Louise Park* (Hamilton General Hospital and University of Toronto certificate course), from Dundas Board of Health to pursue post-graduate study; *Irene Martin* (Hotel Dieu, Cornwall, and McGill University public health course) and *Margaret Goble* (Vancouver General Hospital and University of British Columbia from United Counties health unit; *Eva Rieder* (Massachusetts General Hospital and University of Toronto certificate course) from Waterloo Township as public health nurse.

Victorian Order of Nurses

The Victorian Order scholarships, for the purpose of assisting nurses to take the university course in public health nursing, have been awarded to the following nurses, who are attending the universities indicated:

UNIVERSITY OF TORONTO: *Lorna Conrad, Lyla Groat, Ruth Hammond, Liv-Ellen Lockeberg, Katherine McLellan, Jean Nichol, Donna Wallace, Minnie Samuels, Elizabeth Sharp.*

MCGILL UNIVERSITY: *Leafa Baldwin, Mary Caryll, Evelyn Harrison, Valda Howard, Beulah Mann, Christine Muise, Barbara Munro, Edna Knutson.*

UNIVERSITY OF MONTREAL: *Louise Chevalier.*

QUEEN'S UNIVERSITY: *Ruth Munns, Joan Stewart.*

UNIVERSITY OF BRITISH COLUMBIA: *Eleanor Chamberlayne, Anna Jean Cumming, Verna McCrory, Isabel Neilson, Isla Tuck.*

UNIVERSITY OF WESTERN ONTARIO: *Muriel LaFortune, Helen Marks, Margaret Peace.*

UNIVERSITY OF ALBERTA: *Phyllis Skaftfield.*

The following nurses have been granted special Victorian Order scholarships and are taking advanced study at the universities indicated:

COLUMBIA UNIVERSITY: *Alice Gage.*

MCGILL UNIVERSITY: *Vivian Adair, Lorraine Miller.*

The following nurses, who received Victorian Order scholarships, have completed the university course in public health nursing and have been appointed as follows:

UNIVERSITY OF TORONTO: *Nita Enns,* Port

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Arthur; *Heather Matthew*, Sherbrooke; *Muriel Morgan*, St. Catharines; *Ellen Pocock*, Porcupine; *Maureen Seymour*, Timmins.

McGILL UNIVERSITY: *Willa McClement*, Welland; *Joan Tallon*, Kirkland Lake; *Roxie Anderson*, North York.

UNIVERSITY OF WESTERN ONTARIO: *Elizabeth Berryhill*, Sarnia.

UNIVERSITY OF MANITOBA: *Marion Hellyer*, Prince Albert.

UNIVERSITY OF ALBERTA: *Laurie Fages*, Brockville; *Eileen Williams*, Huntsville.

UNIVERSITY OF BRITISH COLUMBIA: *Elin Johnston*, Trail; *Norma Kenney*, New Liskeard; *Kathryn Smyth*, Guelph; *Irene Sheasby*, Fort William; *Elizabeth Hayden*, Oshawa.

Appointments: *Catharine Murray* (McGill University public health course), Halifax; *Joy Clarke* (Public health nursing degree, McGill University), Moncton; *Gertrude Burns* (University of Ottawa public health course), Saint John; *Mary Boorman* (University of Alberta public health course), Kingston; *Evelyn Stoskopf* (University of Western Ontario public health course), Kitchener; *Katharine MacLeod* (University of Toronto public health course), Sudbury *Marguerite Langdon* (University of Western Ontario public health course), formerly county health unit nurse in Campbellford, Ont., to York Township staff; *Laura Einarson* (University of Manitoba public health course), Winnipeg; *Kersten Nelson* (McGill University public health course), North Vancouver; *Dorothy Richardson*, *Grace Wanner*, *Mary Zeagman*, *Marjery Jackson* (University of Toronto public health course), Toronto; *Jean Wallace* (University of Toronto public health course) and *Mariette Bouchard*, who resigned from the V.O.N. in 1944 to join the R.C.A.F Nursing Service, to Montreal; *Margaret Bawden* (University of British Columbia public health course), Victoria; *Margaret Colwell* and *Winifred Stewart* (University of B.C. public health course), Burnaby; *Phyllis Farmer* (University of Manitoba public health course), Regina.

Transfers: *Harriet McGeary* from Peterborough to be nurse in charge at Belleville; *Dorothy Bluhm* from Winnipeg to be nurse in charge at Braeside; *Mary McLean* from Kingston to be senior nurse at York Township; *Hazel Cryderman* from St. Catharines to be nurse in charge at Kitchener; *Muriel Rice* from Yarmouth to be nurse in charge at North Bay; *Lorna Warman*, formerly staff nurse at St. Catharines, now nurse in charge; *Margaret Joyce* from Cobalt to be nurse in charge

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at Smiths Falls; *Eva Secord* from Hamilton to Lincoln County; *Katherine Maddaford* from Welland to be nurse in charge at Regina; *Phyllis Scouler* from Regina to Vancouver; *Harriet Rainsforth* from Trail to be nurse in charge at Surrey; *Helen Irving* from Vancouver to be nurse in charge at Elphinstone.

Resignations: *Edith Hill* from Oshawa, *Hilda Law* from Fort William, *Mary Blandford* from Windsor (Ont.), *Irene Halford* from Winnipeg, and *Adella Matusaitis* and *Edna Valiquette* from Toronto, all to be married; *Barbara (Linklater) Bell* and *Marion Hatcher* from Toronto; *Marguerite Reis* from Gananoque; *Gertrude Dickie* from Vancouver to take up other work.

M.L.I.C. Nursing Service

The following is information concerning staff changes in the Nursing Service of the Metropolitan Life Insurance Company:

Jeanne Christin (Hotel Dieu, Montreal, and University of Montreal public health course) has been appointed to the nursing staff and posted to Jonquière, P.Q. *Cecile Leclerc* (St. Jean de Dieu Hospital, Gamelin, P.Q.) and *Catharine Lamarre* (Infant Jesus Hospital, Quebec City) have been granted a ten-month leave of absence from the Quebec City staff to take the public health course at the University of Montreal. *Gabrielle Beland* (St. Joseph Hospital, Three Rivers), formerly at Three Rivers, has resigned from the Company's service to be married.

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News Notes

ALBERTA

CALGARY:

The Orientation Program for the forty-five new students at Holy Cross School of Nursing has just ended. For the first time, part of the program consisted of psychometric tests—intelligence, adaptability, personality, accuracy, and general knowledge — given by Professor Dent of Canton, Ohio. The reports show the students to be a well selected group, with all the qualifications necessary to become good nurses and of above-average intelligence. Their success now depends on the individual and the educational program.

This year also the school of nursing is experimenting with the "Block System" of education, whereby the students have no ward assignments for certain periods when they are given a concentrated program of instruction. Between class periods, a strong clinical teaching program on the wards will be maintained so as to ensure good correlation between theory and practice. Although the "Block System" has not yet been adopted by any other hospital in Alberta, it has proven its value in a few schools in Canada and various parts of the United States.

It is hoped that the new system will give the students a better background for nursing without being too rigorous a program to follow. The students have begun with enthusiasm, hoping to achieve higher scholastic standing since being relieved of nursing duties while taking their lectures.

Sister Marie Laramee, a graduate in social service from the University of Montreal and a public health nurse, is now on the staff. Mary Gross, a University of Manitoba graduate, will have charge of the health program for nurses and employees. Violet Molesky, science instructor, has returned from St. Louis University where she has been studying for her B.Sc. in nursing. Mrs. Nora Street, a graduate of St. Joseph's Hospital, Glace Bay, is now nursing arts instructor.

EDMONTON:

Madeline McCulla presided at a recent meeting of Edmonton District 7, A.A.R.N., when Violet Chapman gave a report on the tea held in aid of the Rest-Break Homes. Two hundred and four dollars was raised. Blanche Emerson, A.A.R.N. president, gave an interesting account of the I.C.N. Congress. It was a pleasure to have several district nurses, who were in Edmonton for the Public Health Convention, present at the meeting.

At the opening meeting of the Royal Alexandra Hospital Alumnae Association Mrs. Richardson was in the chair. A shower of groceries and canned goods is to be held for the purpose of sending food parcels to two British nurses. It is hoped that all alumnae members will participate in this project. Mildred Moore and Ruth Haman are conveners for the dance to be held in December.

BRITISH COLUMBIA

CHILLIWACK:

The Cherry Carnival proved to be a busy time for the Chilliwack Chapter, R.N.A.B.C. The general nursing section entered a float in the parade depicting the history of nursing. Nurses were dressed in costumes dating from the days of Sairey Gamp to the 1947 graduate, including nurses of the armed forces. This float won a special prize. A tent for the convenience of mothers with young children, sponsored by the nurses, was well attended. The public health nurses' float, portraying aspects of their program with emphasis on child health centres and nutrition, also won a prize.

At a meeting on September 3 an interesting talk was given by Margaret E. Kerr, editor of *The Canadian Nurse*, and was enjoyed by the members present.

The recent rummage sale, with Mrs. E. Roberts in charge, netted $125.

Additions to the public health staff include: Susie Jones, formerly of the Peace River Unit, who is re-opening the health service at Hope; Betty Pickard to Agassiz.

KAMLOOPS:

Margaret E. Kerr visited Kamloops at the beginning of September and gave an interesting address to the nurses on what makes the National Nursing Journal "tick."

The staff of the Royal Inland Hospital were sorry to say good-bye to two of their supervisors—Olive Lever and Jean Norquay of the maternity and surgical floors. They have given faithful service to the hospital for many years.

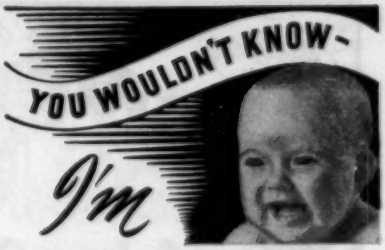
TRAIL:

At a recent meeting of Trail Chapter, R.N.A.B.C., Margaret E. Kerr, *The Canadian Nurse* editor, was the guest speaker when she spoke on the history of the *Journal*. A lively discussion followed this talk, the vote of thanks being extended by the president, Mrs. S. Gavrilick.

VANCOUVER:

Two bursaries of $500 each have been awarded by the Vancouver Chapter, R.N.A.B.C. The recipients were M. Scott, who will enter the University of British Columbia to take public health, and M. Gibson who will go to the University of Manitoba for teaching and supervision.

The following nurses attended the National League of Nursing Education convention held in Seattle: E. Mallory, president, R.N.A.B.C.; A. Wright, executive secretary, R.N.A.B.C. (one of seven Canadian members, N.L.N.E.); J. E. Jamieson, president, Greater Vancouver District Association, R.N.A.B.C.; Mrs. L. Grundy, president, Vancouver Chapter, R.N.A.B.C. In attendance from the Vancouver General Hospital were: E. Kemp, department of nursing; J. Walters, senior instructor; Mrs. M. Shugg, clinical instructor; Mrs. M. Canty, J. Campbell, P. Rowe, M. Duncan. E. Davis and E. Kunderman represented St. Paul's Hospital.



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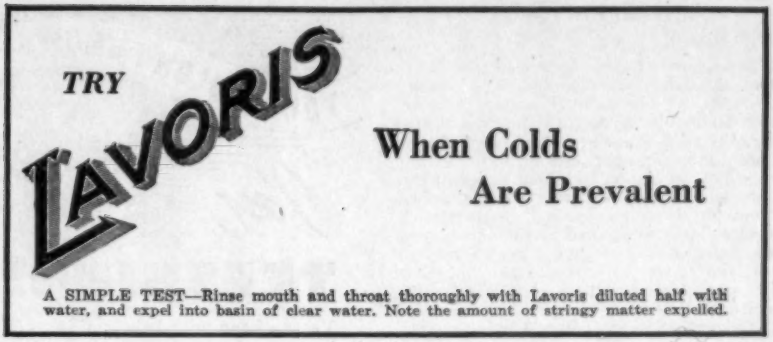
The following nurses have enrolled for the post-graduate course in surgery at Vancouver General Hospital: V. M. Hachey (Edmonton General Hospital), F. O. Hughes (Providence Hospital, Moose Jaw), D. V. Griffiths (Galt Hospital, Lethbridge), M. E. Duffield (McKellar Hospital, Fort William), M. J. Moncrieff (Royal Jubilee Hospital, Victoria), E. Hansen (Calgary General Hospital), J. C. Atkinson (Calgary General Hospital), B. A. Roberts (Saskatoon City Hospital).

St. Paul's Hospital:

Sister Catherine de Balogna, the present sister superior, has been transferred to that of a higher office — Mother Provincial. The nursing staff is very appreciative of the great improvements in the working conditions which have taken place during her term in office and it is with sincere regret that the nurses see her leave to take up her new duties. Heather-Anne Batstone is taking the teaching and supervision course at McGill University.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NEW BRUNSWICK

BATHURST:

It was learned with regret that, due to ill health, Mrs. Mildred Lyons Kent has resigned as superintendent of the J. H. Dunn Hospital. On the advice of her doctor, Mrs. Kent will take a prolonged rest. Mrs. Kent resumed the post a year ago for the second time. The position was to have been temporary but Mrs. Kent remained to run the hospital with which she had been associated for many years before her marriage.

In appreciation of her services as superintendent Mrs. Kent was presented with a travelling bag and make-up case from the medical and surgical staff.

SAINT JOHN:

Among the social activities for those attending the N.B.A.R.N. annual convention held in September were an afternoon tea and dinner at the Admiral Beatty Hotel with Judge Pepperdene as guest speaker. A luncheon was also held at St. David's Church Hall.

General Hospital:

The staff recently entertained in honor of Margaret (Fuller) Smith, a recent bride, who resigned from the supervisory staff. Audrey Ross is now supervisor of the obstetrical department. Josephine Searle is with the operating-room.

Gladys Creelman is taking the public health course at the University of Toronto School of Nursing. Ruth Chase is taking a course offered at the New England Deaconess Hospital, Boston. Doreen Butler is on the general duty staff of the Presbyterian Hospital, New York.

Among the graduates visiting Saint John this summer were: Rosa (Kierstead) Thompson, Evelyn Bedford, Elsie (Shaw) Swicker, Annie Leckie, Doris (Jones) MacDavid, Elva (Stairs) Lynne, Edna (Kelly) Seidler, Rena (MacDavid) Brewster, Marion McAfee.

St. Joseph's Hospital:

Dr. McInerney addressed the graduating class of the training school at their recent exercises. Ann Ruland was the valedictorian. The alumnae association entertained the new class at a dinner and dance.

ST. STEPHEN:

Mabel McMullen, Myrtle Dunbar, Nellie Spinney, Aldana Leland, Ruth Kennedy, Mmes Roy Bartlett and Harry Short attended the N.B.A.R.N. annual meeting in Saint John. Katherine Vaughn, operating-room supervisor at the Chipman Memorial Hospital, sent an interesting poster to the meeting, with an original poem entitled "My Nurse is Near." Glenna Worrell, a first-year student, presented a poster showing procedures in giving medicine.

The new class of students at C.M.H. enjoyed a "corn boil" at the beach of Mill Stream, under the supervision of the dietitian, Jessie Orr, and Jean Menzies, a student. Thelma Briggs, acting superintendent, C.M.H., was honored by the staff members at a dinner previous to her departure.

Helen Boone has been appointed by the St. Andrews District Nurses' Association.

ONTARIO

DISTRICTS 2 AND 3

OWEN SOUND:

Cora Marcella Brooks, recently director of nursing at the General and Marine Hospital, has left for Hawaii where she will become a member of the staff of the Leahi Hospital, Honolulu. Miss Brooks is a Woodstock General Hospital graduate.

DISTRICT 10

The prime requisite of a successful nurse must always be service — service to humanity at large and to the sick, Miss Margaret E. Kerr, editor of *The Canadian Nurse*, told the nurses who gathered at the dinner arranged by District 10, R.N.A.O. This

event marked the annual dinner tendered by the district to the graduating classes of the three lakehead schools of nursing — McKellar, Port Arthur General, and St. Joseph's. Twenty-nine graduates occupied guest seats. Jane Hogarth, who presided for the evening, extended a welcome to the graduates, pointing out that the nurses' association only grew and attained strength as they entered it. Ruth Kirkpatrick proposed the toast to the new classes with F. Dennis responding. Mrs. L. Stanfield led community singing accompanied by M. Walberg at the piano, Gladys Carter, Myrtle Lambert, Betty Harrison, Rosa M. Cross, and J. Chehowy also contributed to the evening's entertainment. The guest of the evening was thanked by V. Weston. Many other graduates of former years were in attendance.

QUEBEC

MONTREAL:

Royal Victoria Hospital:

Taking the teaching and administration course at McGill School for Graduate Nurses are: Mary Harling and Catherine Brown. Mary Lockhart is taking public health.

Recent visitors to the school include: Dorothy (Hayward) Goodridge, Angelyn Rodgers, and Miss Walters, sister-in-charge at Westminster Hospital, London, Eng.

Tannis Hall is taking a six-month course in ophthalmological nursing at Wills Hospital, Philadelphia. Dorothy Ford has accepted a position at the Mt. Hamilton Hospital, Hamilton. Effie Killins, formerly with the registry, is doing special duty.

Maude Dolphin is now head nurse, Ward N, succeeding P. Raymond who resigned. Eloise (Williams) Fleming is surgical supervisor, main building. She has been succeeded by B. Lester as head nurse, 4th floor, Ross Pavilion. Miss Lester has been replaced by Catherine Jefferson as assistant head nurse, 2nd floor, Ross Pavilion. Hilda Sargent has resumed her duties as head nurse, 5th floor, Ross Pavilion. Doris Allison has resigned from the R.V. Montreal Maternity Hospital.

SHERBROOKE:

At the I.C.N. Congress Mrs. Mae Lothrop attended as the Sherbrooke Hospital Alumnae Association representative. She brought back with her an extremely interesting report of the meetings. Also in attendance was Roberta Sutton as the representative for the hospital.

The October alumnae meeting was held jointly with District 3 when the guest speaker was E. Flanagan of the Montreal Neurological Institute.

SASKATCHEWAN

ESTEVAN:

Margaret E. Kerr, editor and business manager of *The Canadian Nurse*, was guest speaker at a meeting and social evening held by the Estevan Chapter, S.R.N.A., when forty-two nurses attended from Weyburn,

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MENTHOLATUM
Gives COMFORT Daily

Oxbow, Bienfait, and Estevan. Miss Kerr was presented with a corsage of roses by M. Niblett, on behalf of the nurses of southern Saskatchewan. Mrs. D. Jardine, prior to her departure for the University of Manitoba where she will take a public health course, received a souvenir gift spoon from Mrs. J. M. Budd on behalf of the chapter members.

MAPLE CREEK:

Margaret Kerr was entertained at a buffet supper at the home of Mrs. A Dixon when she visited here recently.

Prior to a regular meeting of Maple Creek Chapter, S.R.N.A., films on operating-room technique were shown, thanks to the co-operation of the doctors of the local hospital.

MOOSE JAW:

Providence Hospital:

Twenty-four students are registered in the new class. Marg Holman, scholarship student, has left for the University of Manitoba to take a course in surgery. Mrs M. (Webber) Koshnysh, former science instructor, is residing in Fort Wayne, Indiana.

Appointments to the staff are as follows: Mrs. K. Fisher, science instructor; Helen Rutherford, clinical instructor; Alice Ralph, pediatric supervisor; Gertrude Keating, supervisor, medical floor (recently returned from Nova Scotia); general duty, Inez (Blizard) Light, Cecile Maupen, Betty Jones.

PRINCE ALBERT:

Agnes Campbell is now superintendent of nurses at the sanatorium. Millie Turner has returned to Victoria Hospital as instructor. Mrs. V. McCrory is taking a post-graduate course at the University of British Columbia and has been replaced on the V.O.N. staff by Miss Hellyer. Miss Goplin is on the O.R. staff at the Winnipeg General Hospital. Alice Jacobsen is instructing at Holy Family Hospital.

REGINA:

Margaret Kerr spent several days in Regina in September and during her stay spoke to the students at the General and Grey Nuns' Hospitals, when also approximately seventy-five graduate nurses heard Miss Kerr.

Elizabeth Smith, director of the Provincial Public Health Nursing Service, recently attended a convention in the east. P. Jones, E. Brown, J. McCleneghan have been added to the city public health staff, while Mrs. Dunnett, a returned nursing sister, resigned to make her home in Vancouver. E. Barton has also left to take a public health course at McGill University.

Several nurses from the provincial and city health departments have obtained experience at the polio clinic of the General Hospital, including Misses McCann, Hopkins, S. Brerh, A. McDonald, R. Dunn, and Mrs. Martin.

General Hospital:

At the "capping ceremony" twenty-eight students participated when it was held at the end of July. Ethel James, first vice-president, S.R.N.A., has joined the staff as educational director. Agnes Swenseid, winner of the 1947 Carss Scholarship, is at McGill University for the teaching and supervision course. Margaret (Sim) Hudec has returned to duty as assistant night supervisor. Mrs. Mathews, formerly with the provincial public health department, is public health instructor.

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CPL

Grey Nuns' Hospital:

The first "capping ceremony" in the history of the school of nursing was recently held.

Goldie Jack, station nurse, who has resigned to be married, has been replaced by Mrs. Appenheimer. Miss Rodgers has taken over the position of head nurse, 1st floor, replacing F. Rooney who resigned. J. Trembly is now station nurse, while E. Hagar, of the children's ward has joined the public health staff. Mrs. A. MacDonald is assistant nursing arts instructor. G. Spice is replacing K. Probert as science instructor. E. Jefferson is now surgical clinical instructor while A. Lacour is medical clinical instructor.

Miss Nicholson is welcomed back after nursing in Central America. P. Graham is doing public health nursing in Assiniboia district. H. Schmidt has left the children's ward to become Dr. R. Brown's office nurse. E. Hagar has also left the same ward to become a public health nurse in North Battleford district.

SASKATOON:

Dorothy Code has resigned as president, Saskatoon Chapter, S.R.N.A., to continue post-graduate study in Toronto.

City Hospital:

The new class is composed of forty-four students. A complete Block System has been established for second-year students taking classes. In addition, student nurses are being placed on a 48-hour week.

Appointments to the staff include: M. Rose, operating-room; Mmes Russell and Laird, general duty; Mmes Newby and Corbet, maternity; Miss Lee, Children's ward. G. Schuman has resigned as medical clinical instructor. L. Knighton, former assistant night supervisor, is now supervisor of E-4.

St. Paul's Hospital:

A class of forty-two students was registered in September. An enjoyable evening was sponsored by the "Big Sisters" before the new students commenced studies. A hearty welcome is extended to Rev. Srs. Quintal, Bedard, Cayouette, and Boucher. Sr. Quintal is the new clinical instructor and a graduate of Marguerite d'Youville College. Irene Mandin, instructor of nursing arts, has resigned, and is replaced by E. Worobetz. Leona Costello is now supervisor on the obstetrical ward. Ann Beechinor is welcomed back from Montreal after taking a course in pediatrics. Sr. A. Bonin has left Saskatchewan for Alberta.

The school of nursing was recently visited by a former graduate — Mrs. P. M. Riffel of Nokomis.

WEYBURN:

During her visit to Weyburn, Margaret E. Kerr was the guest of Miss Copeman, superintendent of the Saskatchewan Training School. Mrs. H. E. Mitchell, Weyburn Chapter president, Miss MacDonald, superintendent, General Hospital, and Mrs. Fletcher, public health department, acted on behalf of the hostess association.

Positions Vacant

Superintendent for Blanchard-Fraser Memorial Hospital, Kentville, Nova Scotia. Apply to Secretary, P.O. Box B, Kentville, N.S.

Operating-Room Nurses for 185-bed Children's Hospital. All graduate staff in O.R. 8-hour day and 5½ day week. 1 month holiday with salary per annum. Salary: $100 per month with $5.00 increase each 6 months to $110. Full maintenance. Apply to Director of Nursing, Children's Memorial Hospital, 1615 Cedar Ave., Montreal 25, P.Q.

Qualified Dietitian for General Hospital. Good salary and full maintenance. Apply to Administrator, General & Marine Hospital, Owen Sound, Ont.

Nursery Supervisor with post-graduate experience. Apply, stating qualifications and experience, to Supt. of Nurses, General & Marine Hospital, Owen Sound, Ont.

Public Health Nurses (qualified - 2). Applications will be received up to 10 a.m., Thursday, November 20, 1947. Apply, stating qualifications, age, experience, and salary expected, to Dr. C. A. Warren, Medical Officer of Health, Township of York, Keele St. & Elora Rd., Toronto 9, Ont.

General Duty Nurses for 80-bed General Hospital in Southern Ontario. Salary: $115 per month (including pay for O.R. call and bonus), plus maintenance. Increase at end of 6 months to $120 and at end of a year to $125. 8-hour day and 6-day week. 2 weeks' holiday with pay (3 weeks given at end of 2nd year.) Allowance for sick leave, hospitalization, and statutory holidays. Additional $5.00 per month paid for 3:30 shift. Apply, stating qualifications and date available, in care of Box 8, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, P.Q.

Matron. Salary: $150 per month plus maintenance. **Graduate Nurses** (2). Salary: $120 per month plus maintenance. 16-bed hospital. Apply to Municipal Hospital, Magrath, Alta.

Superintendent of Nurses for Victoria Public Hospital, Fredericton, N.B., a 150-bed hospital. Apply to Mrs. B. H. Hagerman, Chairman, Nurses' Committee, 62 Alexandra St., Fredericton, N.B.

Instructor (qualified) immediately for 60-bed hospital. Apply, stating qualifications, experience, and salary expected, to Supt., Payzant Memorial Hospital, Windsor, N.S.

Public Health Nurses. Minimum salary: $2,000 with provision for annual increases to $2,700. 3 weeks' vacation with pay; pension plan; car provided. Qualifications: Preferably not over 35 years of age; public health training; public health experience; special orthopedic training if possible. If the latter is not considered sufficient, a 6-month in-service training will be given at slightly reduced salary. Apply to Director of Nurses, Ontario Society for Crippled Children, 112 College St., Toronto 2, Ont.

Operating-Room Nurse. Salary: $110. Full maintenance, laundry, Blue Cross Hospitalization. $60 yearly increase up to 3 years. **General Floor Duty Nurse.** Salary: $100. Same benefits. Apply, with references, to Supt., Barrie Memorial Hospital, Ormstown, P.Q.

General Staff Nurses. Salary: $140 per month living out, plus laundry. Annual increment. **Operating-Room & Recovery-Room Nurses.** (Post-Graduate course essential.) Salary: $145 per month living out, plus laundry. Annual increment. Accumulative sick leave. Hospitalization. Superannuation. 31 days' vacation. Statutory holidays. 8-hour day and 6-day week. State in first letter date of graduation, experience, references, etc., when services would be available, and whether eligible for registration in British Columbia. Apply to Director of Nursing, General Hospital, Vancouver, B.C.

General Staff Nurses for 150-bed Sanatorium. Salary: $120 per month plus full maintenance. 4 weeks' vacation with pay each year. 14 days' sick leave. Additional $10.00 per month for night duty. Railway fare refunded after 6 months' service. Apply, stating qualifications and date available, to Supt. of Nurses, Niagara Peninsula Sanatorium, St. Catharines, Ont.

Graduate Nurses for **General Duty** in 350-bed **Tuberculosis** Hospital. Salary: $110 per month plus full maintenance, with yearly increments of $5.00 a month to a maximum of $125. 6-day week with 6 hours of duty on Sunday. Good living conditions. Apply to Miss M. L. Buchanan, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q.

Graduate Nurses for **General Duty** in 19-bed hospital. Salary: $110 per month with full maintenance. Separate nurses' residence. Apply to Miss M. Sissons, Matron, Municipal Hospital, Vulcan, Alta.

WANTED
ASSISTANT EXECUTIVE SECRETARY
for
Registered Nurses' Association of British Columbia

Duties: To carry out the Labor Relations Program of the Association and to interpret it to nurses, employers and the public; to study and advise on Personnel Practices for nurses and to assist with the Association's Public Relations Program.

Further information may be obtained from:
Miss Alice Wright, Executive Secretary,
1014 Vancouver Block, Vancouver, B.C.

Registered Nurses for **General Staff** at Tranquille Sanatorium, which is situated on Kamloops Lake, near Kamloops, B.C. Gross salary for 8-hour day, 6-day week: $146.11 per month during 1st year; $156.11 per month during 2nd year; and a $5.00 per month raise in 3rd, 4th, and 5th years of service, minus $27.50 monthly for board, room and laundry. 31 days vacation per annum with pay, plus 11 days statutory holidays. 14 days sick leave each year, accumulative, with pay, plus 6 days incidental illness. Superannuation plan. Up to $50 of fare refunded. Apply to Supt. of Nurses, Tranquille, B.C.

General Duty Nurse. Salary: $100 per month. 10% Xmas bonus. 8-hour duty. All meals allowed. Uniforms laundered. Apply to Rotary Hopewell Hospital, Leamington, Ont.

Assistant Director of Nurses for Toronto Psychiatric Hospital (University of Toronto Psychiatric Centre). Applicants must be experienced in Nursing Administration and Psychiatric work. The post provides an outstanding opportunity for fostering Psychiatric Nursing in all its aspects. Living out: Initial salary, $2,140. For further particulars and application forms apply to Director of Nurses, Psychiatric Hospital, Surrey Place, Toronto 5, Ont. (*Closing date for applications November 15, 1947*).

Night Supervisor for 120-bed hospital and Training School. Prospective new hospital. Salary by negotiation. Also **Operating-Room Supervisor & Dietitian.** Apply to Supt. of Nurses, Galt Hospital, Lethbridge, Alta.

Nurse with knowledge of **Urinology and Hematology** for part-time Laboratory work. High salary. 8-hour day. Living-in accommodation. Apply to Supt., Alexandra Hospital, Ingersoll, Ont.

Registered Nurses for General Duty at Queen Alexandra Solarium for Crippled Children, Cobble Hill, Vancouver Island, B.C. 26 miles north of Victoria. Gross salary: $140 per month with annual increases up to $160, plus laundry. 8-hour day and 6-day week. Hospitalization Plan provided. 2 weeks' sick leave per year. 1 month vacation each year. Solarium situated on beautiful Mill Bay giving ample opportunities for boating, fishing and outdoor life. State in first letter date of graduation, experience, when services available. Apply to Lady Supt.

Night Supervisor. Salary: $155 per month plus full maintenance. 6-night week. **Medical Ward Supervisor.** Salary: $145 per month plus maintenance. Apply to General Hospital, Chatham, Ont.

Marriage and Nurses

"Why do nurses leave their jobs?"

Most of them quit to get married, reports the U.S. Bureau of Labor Statistics following a study of nursing based on replies to 22,000 questionnaires circulated in February and March. The study covered all branches of nursing and was undertaken at request of the National Nursing Council.

"Most nurses who quit nursing do so to marry rather than to take other jobs. Of registered nurses not working at present, less than 10 per cent are employed or seeking employment outside nursing. Nurses generally derive satisfaction from their work, but dissatisfaction with some conditions of the profession is great enough to constitute a serious problem. No provision for retirement, no security against unemployment, present rates of pay, and promotion and pay-raise policies were the chief complaints."

The Pacific Coast was credited by the report with the highest monthly earnings for nurses and hours somewhat shorter than those in other sections of the country.

—*California's Health*